Violence and Teen Pregnancy

A RESOURCE GUIDE FOR MCH PRACTITIONERS

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Children's Safety Network

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Children's Safety Network

National Injury and Violence Prevention Resource Center

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Table of Contents

Executive Summary

Violence against pregnant women is a complicated and serious health problem. When abuse is directed against a pregnant teenager, the issue becomes even more complex, since the risks due to violence exist in conjunction with other adolescent health risks—delayed and sporadic prenatal care, inadequate nutrition, and use of alcohol and other drugs.

Maternal and child health professionals have numerous opportunities to communicate key prevention and intervention messages to and about adolescents. The programs and resources described in this guide present examples of how practitioners at the local and state levels are actively responding to the possibility of violence in the lives of pregnant women and teens.

There are special considerations when responding to the needs of a pregnant and abused adolescent. Her situation must be viewed not as an isolated crisis, but as a convergence of three problems: adolescent pregnancy, violence against adolescents, and violence against pregnant women of any age. At the same time, this convergence creates a new challenge, with distinct features and needs:

- Standard domestic violence prevention models may not fit a teenager, who may be abused by her parents and other family members, as well as by her partner.
- Different laws apply when a pregnant teen is beaten by a parent or other guardian.
- The partner of a pregnant adolescent is often significantly older than she is, and beyond the reach of school-based violence prevention programs; the possibility of coercive or forced sex must also be addressed within these relationships.
- Girls who have been sexually and/or physically abused are at greater risk of becoming pregnant than their nonabused peers.

Pregnant abused teens often "fall through the cracks" of social services. Programs for battered women do not always reach or serve minors or women who are battered by persons other than their partners. Services for teens in violent relationships cannot always accommodate girls with infants. Dating violence prevention programs only infrequently address the needs of pregnant teens, and teen pregnancy prevention programs do not always incorporate violence prevention components.

Maternal and child health practitioners can design their programs to screen and reach pregnant teens at risk of being abused. Programs serving adolescents can include violence prevention, screening, and intervention elements; violence prevention programs can incorporate the special needs of pregnant and parenting teens; and programs serving pregnant girls can be sensitized to recognize and respond to violence and abuse.

How to Use This Guide

> . . . sometimes almost strangled by him, at other times thrown to the floor and stamped on, with him swearing he would murder her . . . Such cruel usage, from a man who ought to have been her best friend.
>
> —*Pennsylvania Gazette*, August 10, 1785[162]

To be a teenager . . . pregnant . . . and abused is frightening and overwhelming. Health professionals and other practitioners who work with adolescent girls can help, if they have the knowledge, tools, and support to do so. This resource guide is designed to:

- provide information on the scope of this problem
- identify what is known about violence and teen pregnancy, and what remains to be learned
- describe the tools and techniques that have been developed to address this complex problem

The guide is primarily directed at maternal and child health (MCH) professionals—providers of health services, both directly and indirectly, to mothers, children, and adolescents. Domestic violence practitioners, youth workers, and others with an interest in adolescent health, pregnancy prevention, and violence prevention should also find it useful.

Part I of *Violence and Teen Pregnancy* synthesizes and discusses relevant literature from a variety of fields. By drawing on studies and publications from public health, social work, domestic violence, and other arenas, we hope to assist providers in learning from one another's experience and achievements in order to better serve teens who are at risk of being victimized. The text is thoroughly referenced for those who wish to more fully explore the literature. We have also highlighted the personal nature of violence during pregnancy by including vignettes drawn from true accounts.

Part II presents practical steps and measures that can be taken by state and local MCH professionals, including screening, assessment, referrals, counseling, collaboration, and training. Throughout this guide, we refer you to specific programs and resources that describe additional measures to take.

Part III is a reproducible "toolkit," providing basic questions that need to be included when serving pregnant teens, discussing techniques for addressing their needs, and reprinting a flow chart produced by the Greater Bay Area (California) Chapter of the March of Dimes Foundation.

In Part IV, we describe 12 programs that present a variety of strategies for addressing the problem of violence against pregnant women, especially pregnant teens. The programs are found in a range of settings in which MCH or other public health practitioners work, such as prenatal clinics, WIC clinics, state and local health departments, new mother home visiting programs, and health maintenance organizations (HMOs). We urge you to contact the programs and use the resources described within these pages. These are examples of some of the innovative and ongoing ways in which practitioners are responding to the problem of abuse during pregnancy.

Part V consists of an annotated list of additional key resources—including brochures, videos, slides, patient materials, and curricula.

We hope you find this guide useful and invite your responses. Please contact the author directly with your comments and suggestions:

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Part I

The Crisis of the Abused Pregnant Teen

The adolescent who is pregnant and abused presents a complex challenge to those who are charged with serving her needs. Violence against pregnant teens (who, for the purposes of this guide, encompass ages 12–18) needs to be understood not as an isolated crisis but as a convergence of the problems of teen pregnancy, domestic violence, and violence against pregnant women of all ages. At the same time, the overlap of these situations creates a new hybrid problem, with distinct features and needs. Abused pregnant teenagers face unique barriers to their efforts to avoid, cope with, and report abuse. For the MCH practitioner, diagnosing, responding to, and preventing violence against a pregnant teen is not the same as dealing with an adult woman: there may be different legal issues involved; services may not be as available to minors; the girl's education is at risk; and the pregnant teen is already at a heightened risk of delayed prenatal care and poor birth outcome. MCH practitioners need to recognize who is at risk, who presents a threat, what constitutes abuse, what the effects of abuse are, and what kinds of services are available and accessible to teens.

Despite the complexity of the issue, there are strategies that MCH practitioners can use to both prevent and intervene in violent relationships. With adequate training, tools, and services, and in collaboration with other violence prevention colleagues, MCH practitioners can effectively employ these strategies.

Scope of the Problem

To understand the connections between interpersonal violence and adolescent pregnancy, we first examine the scope of domestic violence* and then consider violence that occurs during pregnancy.

Domestic Violence Is All Too Common

Although statistics vary due to differing collection methods and definitions of domestic violence, the data clearly show that domestic violence is a widespread problem throughout American society:

- A national telephone survey of women ages 18 and over found that 7 percent (3.9 million) of women who were married or living with someone had experienced physical abuse, such as being hit, kicked, choked, beaten, or threatened with weapons, in the previous year. Ninety-two percent of these women did not discuss these incidents with their physicians, and 57 percent said they did not discuss them with anyone.[41]

- The National Crime Victimization Survey indicates that 29 percent of all violence by a single offender against women ages 12 and older was committed by an intimate partner or ex-partner. In addition, violence by intimates led to injuries more frequently than violence by strangers did.[13]

- It is estimated that 8 to 12 percent of women experience some form of domestic violence within a one-year period.[184]

- While women of all ages can be at risk of being physically or sexually abused, this risk is greatest between the ages of 16 and 30, a period that often coincides with the childbearing years.[7,11]

*A substantial body of literature exists on "domestic violence," "spouse abuse," "battering," "intimate violence," and "partner abuse." Each of these terms is a different way of referring to what the California Department of Health Services describes as "a pattern of assaultive and coercive behaviors, including physical, sexual, and psychological attacks as well as economic coercion, that adults and adolescents use to achieve control over a past or present intimate partner."[85]

> When we were going together when I was pregnant he would like threaten to kill me, and he would hit me and stuff like that. . . . He started going out with somebody else and he didn't want to see me no more, so we just broke up. And I just had the baby, and he never seen the baby. He's never seen it.
>
> —14-year-old girl [63]

Abuse Frequently Occurs During Pregnancy and More Often to Pregnant Teens

- Estimates of abuse during pregnancy range from 6 to 17 percent of all pregnancies. [5,17,25,34,81,108,109,132]
- Four to 21 percent of abused women report being abused during pregnancy.[41,168]
- Fifty-four to 100 percent of women interviewed within battered women's shelters report having been abused while pregnant.[32,49]

Although most of the research on domestic violence has focused on women over the age of 18, there is evidence that pregnant teenagers are abused more than pregnant adult women are. Both pregnancy and adolescence are times of risk for abuse; therefore, it is not surprising that studies of pregnant teens show consistently higher rates of abuse:

- Twenty-six percent of pregnant teens in a West Virginia study had been abused, compared with 10 percent of adult women.[51]
- In another study, 22 percent of urban, low-income pregnant teens reported current abuse, while 16 percent of pregnant adult women reported such abuse.[129]
- A study of low-income, urban pregnant women and teens found that almost one-third of the girls were abused, although less frequently and less severely than the one-quarter of adult women who were battered.[132]
- In a sample of pregnant teens interviewed for a history of assault, 40 percent of those who were physically abused had been hit during pregnancy.[15]
- Twenty-six percent of pregnant teens in an urban public prenatal clinic described abuse by their male partners; of those, 40 to 60 percent reported that abuse had begun or increased since discovery of the pregnancy.[30]
- Among girls in a shelter for displaced teens, 41.5 percent reported that they had been battered while pregnant.[143]

> One day Matt drank some Margaritas and we ended up arguing. He smacked me and my nose bled . . . I was around 4 or 5 months pregnant . . . Matt put his legs around me . . . he threatened to squeeze me so I'd lose the baby. He didn't want me to leave with his baby. We fought and argued a lot then.
>
> —Teenage girl [117]

The data that are available to us may well underestimate the problem. The prevalence of domestic violence during pregnancy has been estimated primarily through studies within prenatal clinics and emergency rooms and through small surveys of residents at battered women's shelters. None of these snapshots presents the whole picture: clinics tend to be used by low-income and urban patients rather than by the general population; emergency room settings include only those women whose injuries are serious enough to warrant immediate medical attention and may miss those who seek treatment from private practitioners. Shelters serve the minority of battered women who have left the violent relationship. Some studies have not specifically inquired about sexual violence, and many studies eliminate all women who miscarry or abort. Further, many rates of abuse during pregnancy have been derived from screening only once during prenatal care.

Partners Are Not the Only Abusers of Teens

It is critical for practitioners to recognize that this abuse does not always occur at the hands of the teens' partners. As we shall see in Part II, the relationship of the abuser to the pregnant adolescent makes a crucial difference in how to respond to her situation.

- A study of pregnant teens found 23 to 46 percent reporting abuse by a member of their family of origin.[17]
- Another study within a prenatal clinic found that one-quarter of the teens battered during pregnancy identified a family member as the one who hurt them; another quarter reported being beaten by *both* a family member and a mate.[15]
- While 12 percent of pregnant women reported abuse at the hands of "others" (including parents, other relatives, and girlfriends), more than 27 percent of pregnant teens identified their abusers as "others." Almost twice as many teens reported multiple abusers.[132]

Insufficient Attention Has Been Paid to This Problem

The message that domestic violence can and does occur to pregnant women and can contribute to poor maternal and fetal outcomes has not yet reached the lay press. We reviewed more than 50 recent books on birth, prenatal care, and miscarriage issued by mainstream publishers for expectant parents. Only one, a prenatal care guide written by the American College of Obstetricians and Gynecologists (ACOG),[8] mentioned domestic violence in any way.

While preparing this guide, we conducted an extensive literature search among medical, nursing, social work, and other professional journals and found significant gaps in the recognition of and response to violence against pregnant women and teens. Medical literature on trauma to pregnant women tends to focus on the nature of the injury and its outcome, rather than on cause or motivation. When causes are addressed, motor vehicle crashes and gunshot wounds are the primary causes.[95,135,136,142,160] One writer noted that women sometimes claimed they had been in auto accidents or had fallen when in fact they had been beaten.[49] Articles describing risk factors for premature birth, miscarriage, and low-birthweight babies also frequently fail to include violent trauma as a contributing factor. For example, a major review article on the epidemiology of preterm birth discussed 35 factors that could cause prematurity, but violence and trauma were never mentioned.[22]

Healthy People 2000, the national prevention initiative to improve the health of Americans, includes objectives to reduce the rates of adolescent and unintended pregnancies, abuse of children, abuse of women by their male partners, assaults among people ages 12 and older, and rape and attempted rape. Additional objectives set goals for reducing the incidences of low birthweight and severe complications of pregnancy and for increasing prenatal care and adequate emergency housing for battered women and their children. But Healthy People 2000 includes no objectives for reducing rates of violence against pregnant adolescents and women or for screening for violence in any setting other than emergency rooms.[178]

Finally, the extensive literature that exists on domestic violence too often neglects pregnancy as a risk factor for abuse. The special needs and concerns of pregnant battered women are often not addressed, and service providers for pregnant women are targeted by these materials only infrequently. (See Resources in Part V for information on materials that meet the needs of these audiences.)

Pregnancy: A Vulnerable Time

> He would smash things; he almost choked me a few times. The only time he would leave me alone is when I pretended I was dead, or when I was pregnant.
>
> –Young woman [161]

Most studies have shown an increased risk of abuse during pregnancy, both to women already abused in their relationship and to women who had not previously been abused. However, some women report that for them, pregnancy provided a respite from violence. In any case, when an abused woman or teen seeks prenatal care, the practitioner has an opportunity to counsel her about her options.

Pregnancy Can Be a Risky Period

The strongest predictor of abuse is prior abuse. Therefore, documentation of abuse in a patient's medical history gives a signal to her current health care providers to be vigilant for signs of victimization.

But pregnancy itself is also a risk factor for abuse. For a large number of victims, this is the time when abuse first begins. For others, abuse begins before pregnancy and continues throughout it, often with an increase in severity and frequency.[15,32,105] Studies that screen women during the first prenatal visit only have found lower rates of abuse than studies that screen during the third trimester, indicating that the possibility of abuse increases as the pregnancy progresses.[125]

The American College of Obstetricians and Gynecologists,[6] American Nurses Association, U.S. Preventive Services Task Force,[180] Surgeon General,[177] and others have recommended that all pregnant women be screened for abuse during prenatal care. (See Resources in Part V for where to find materials and trainings to assist with screening.) But clearly not all pregnant girls and women are victims of violence. Who is at greatest risk?

- Women reporting that the pregnancy was *unintended* have a much higher prevalence of violence,[65] and studies have shown that the majority of teenage pregnancies are unintended.[59]
- Rates of abuse among pregnant *teenagers* are frequently found to be higher than those among adult pregnant women.[129,132]
- *Abuse of alcohol and other drugs by a partner* has been associated with an increased risk of violence.[5]
- *Abuse of alcohol and drugs by pregnant women*[17,99] *and teens*[16] has been associated with an increased risk of physical abuse.

Finally, in the absence of clear markers, providers must be open-minded about the potential for any pregnant patient to be abused. Therefore, universal screening throughout pregnancy and the postpartum period is recommended.

Disclosure of Pregnancy

We have yet to learn whether and in what circumstances the disclosure of pregnancy might trigger a violent reaction. One researcher did find that "confirmation of pregnancy was felt to precipitate violence for a few of the patients."[84] In general, surveys of pregnant teens have apparently not asked whether the girls were hurt when they revealed that they were pregnant, but it is not unreasonable to presume that some teens will be at risk when they tell their parents, partners, or others. More research is needed on this issue.

Pregnancy Can Also Provide a Respite from Abuse

For some women who are in violent relationships, pregnancy may be a safer time. Some women who had previously been battered report that the abuse ceased once they became pregnant.[5,15,33,34,84] This aspect of domestic violence has not been adequately explored. However, a brochure from ACOG does point out that "abuse may decrease during pregnancy. In fact, some women feel safe only when they are carrying a child . . . This may lead to repeated pregnancies as a way of escaping abuse."[6]

Since pregnancy can be a protective period, a negative screening is not conclusive. Studies examining violence throughout the childbearing year have found high rates of abuse during the postpartum period.[70,131,170] Even if pregnancy has been a protective time for an abused woman, she may lose that respite once the baby is born. If she has never been battered before, violence may first occur during the baby's infancy, or when she begins a new relationship. Regular and repeated screening by providers increases the chances of detecting new or renewed abuse. This not only allows for early intervention but also helps the woman recognize that screening for violence is routine and that the provider is committed to assisting her.

What Practitioners Can Do:

- **Continue screening on a regular basis before and after birth.**
- **Incorporate violence prevention and detection elements into home visiting programs.[126] (See the Elmhurst Hospital Center's Maternal and Child Home Health Care Program, p. 32, and the Injury Prevention for Pregnant and Parenting Teens program, p. 36.)**
- **Provide assistance to teens who need help in disclosing their pregnancy to others.**

The Relationship Between Violence Against Teens and Pregnancy

Pregnant girls and women are at greater risk of being physically abused than their peers who are not pregnant. There is also substantial evidence that girls with a history of abuse (including sexual abuse, incest, and physical abuse) are at greater risk of becoming pregnant. Pregnancy can occur as a direct result of sexual assault or indirectly, as the girl engages in riskier behavior. For practitioners who serve both pregnant teens and teens who have been victimized, the following are special considerations to bear in mind to help protect them from further negative consequences.

Adolescent Girls—Whether Pregnant or Not—Are at Risk of Abuse

The rate of violence among all teens is high—and rising. Homicide, suicide, and violence against adolescents have increased dramatically within the past 15 years.[159] Almost half of all forms of child maltreatment are perpetrated against adolescents.[139]

> So let's say you have a boyfriend and you're 15 years old and he tells you he loves you and is always gonna be here for you and finally you let him talk you into having sex and he leaves you. Is that abuse?
>
> —Entry in a girl's journal [117]

Violence Occurs Within Dating Relationships

Dating violence exists in far too many adolescent relationships. Although there are no national statistics on the rate or extent of dating violence, surveys and studies have found it to be a common occurrence among adolescents.[21,117,137,143] An analysis of one state's restraining orders provides information on teenage batterers, most of them aged 16–17 (n = 757):

- Almost 57 percent of the restrained teens were in a dating relationship at some time with the victims; the same percentage had prior arraignments for violent offenses.
- Only 13 percent of the restraining orders were taken out by parents intervening on behalf of their daughters.
- At least one-third of the restrained adolescents were parents themselves, and the restraining orders specified that they surrender custody of the child or children to the plaintiff.[100]

Another survey found that dating violence tended to occur within a relatively long-term relationship, that the relationship did not end as a result of the violence but persisted, and that the violence recurred. Almost 80 percent of girls who had been physically abused continued to date their attackers; more than half continued to date the partner who had been sexually violent toward them.[21] A third study found that 65 percent of physically abused teens had not talked with anyone about the abuse, and none had reported it to law enforcement officials.[30] These characteristics are quite similar to those found in violent marriages and other adult relationships.

Yet abuse occurring in intimate teenage relationships is not generally considered domestic violence. We label it "dating violence," indicating that the relationship may have existed for only a short time, that the partners may not be living together, and that no legal bond exists between them. However, the term dating violence also implies that the relationship is transitory, that the partners are peers, and that the emotional impact of the violence is not as serious as that experienced by older women in longer-lasting, legal relationships. These assumptions may not be true: certainly, the relationship seems significant to the adolescents involved, and the data will show that babies born to teen mothers are often fathered by much older men, not peers.

Adolescent Girls Are Also Beaten by Family Members and Peers

Domestic violence programs cannot simply be tailored to fit a younger clientele. Although teenage girls are often battered by a boyfriend, husband, or former partner, the perpetrators are not always partners. Many abusive incidents occur at the hands of relatives and other adults.[55] When asked, teens name their parents, foster parents, siblings, grandparents, and other family members as the persons who hit them. These incidents may be considered cases of child abuse and require reporting to child protective services. (See p. 23 for a flow chart indicating how to respond to adolescent abuse victims depending on the perpetrator's age and relationship to the adolescent.)

In addition, although peer violence prevention is not usually incorporated into domestic violence programs, it needs to be considered when dealing with violence during adolescent pregnancy, as the following example shows:

> Two 16-year-old Nashville girls were charged with first-degree murder in the death of a six-month-old fetus after kicking the mother in her stomach. The mother, age 15, was attacked in the high school parking lot after a football game. Police said one of the older girls was three months pregnant and apparently was "upset" to learn that her partner had also fathered the other girl's baby.
>
> —November 4, 1992

Teen pregnancy prevention programs and peer violence prevention programs can collaborate in order to share successful approaches, efficiently present their messages, and effectively reach girls in need of both services.

What Practitioners Can Do:

- **Assess adolescents for relationship violence as well as for family violence within health care, social work, and social service settings.**
- **Become familiar with community resources and laws relevant to teens in violent relationships.**
- **Ask adolescent victims whether they have ever obtained a restraining order or contacted law enforcement officials about the abuse. This history is another indication of risk for continued abuse and can lead to a discussion of legal options for the victim.**

Sexual Abuse and Assault Can Lead to Premature Pregnancy

Forced sexual experiences—including coercion by a partner or adult, assault by an acquaintance or stranger, or abuse by a family member—are all too common in adolescence.

- Fifteen percent of 14–17-year-old girls in one study reported that someone they were dating had tried to force them to have sex against their will.[55]
- A survey of students in three midwestern high schools found that more than 15 percent of girls and more than 4 percent of boys

had experienced sexual violence within a dating relationship. Most victims did not tell anyone; of those who did, all chose to tell a peer. Only a small percentage also revealed the assault to an adult confidant.[21]

- In another survey, 26 percent of female students reported forced sex; only half had told anyone about it.[46]

- Girls in another study who had experienced dating violence were more than twice as likely to have also been forced to have sex.[137]

- In a survey of 445 pregnant and parenting teen mothers, 61 percent reported having been sexually abused—primarily by stepfathers, boyfriends, guardians, and the boyfriends of their own mothers. The average age of first occurrence was 11.5 years. Twenty-three percent of the girls reported having been impregnated by their abusers.[117]

- Eleven percent of girls in another study reported becoming pregnant as a direct result of rape.[27]

Coercive, forceful, or nonconsensual sex leaves little room for contraceptive choices. It is therefore no surprise that girls who have been sexually abused or sexually assaulted become pregnant. Battered women and girls report that they cannot ask their abuser to use a condom without suffering retribution from him, and are thus exposed to the risks of pregnancy and sexually transmitted diseases (STDs). Focus groups of survivors report that decisions about contraceptives are one of the many issues the abuser controls.[35,70] Teenage girls who have experienced dating violence and forced sex are less likely to use oral contraceptives or condoms and are more likely to agree that men have "a right to be angry" at women who request that they use condoms.[137] For abused girls, "voluntary and rational choices are unlikely to impinge on what has been a long course of involuntary action."[27]

Sexual assault and abuse need to be addressed by practitioners in conjunction with other risks to adolescents, including violence, alcohol and other drug use, and homelessness. The presence of one problem often leads to others: girls who had been abused sexually prior to becoming pregnant began sexual activity a full year earlier than nonvictimized pregnant teens, were more likely to use drugs and alcohol, and were less likely to use contraception.[27] These girls were also more likely to have been physically abused by their partner and to have had their children removed from them by child protective services.[27] A teenager who has been kicked out of her home for pregnancy or other reasons may turn to a boyfriend or other man who demands sex as payment for rent. Abused and homeless teens are more likely to trade sex for money, drugs, or a place to stay[27,56] and to end up pregnant.[35]

What Practitioners Can Do:

- **Address issues of sexual and physical abuse and coercion within family planning and STD clinics.**
- **Include sexual assault as part of violence assessment. Such questions can be broad ("Are you now or have you ever been hurt physically or sexually by someone close to you?"), or they can be a series of more direct questions.**
- **Develop programs to build trust between vulnerable adolescents and responsible adults. (See Partners for a Safe Future, p. 38, as an example of a program that provides pregnant teens with an adult mentor.)**
- **Include a component on violent relationships within discussions about safe sex in HIV education and pregnancy prevention programs. Recognize that negotiating condom use may not be a safe option for some girls and young women.**

Adolescent Pregnancy

An estimated 1 million teenage girls in the United States become pregnant each year; half of these conceptions result in live births. In 1990, approximately 10 percent of girls ages 15 to 19 became pregnant.[39] In 1994, the birthrate for teenagers ages 15 to 17 was 37.6 per 1,000, a 3 percent drop since 1991. But the birthrate for 10–14-year-olds (1.4 per 1,000) remained unchanged.[181]

Abused Pregnant Teens Often Engage in Unhealthy Behaviors

Abused pregnant teens are doubly burdened with obstacles to a healthy pregnancy by the risks associated with both premature pregnancy and violence. Most pregnant adolescents tend to have poor prenatal practices, inadequate nutrition, and delayed prenatal care. The younger they are, the more pronounced these tendencies are.[64] And pregnant teens who are abused are at even greater risk of poor prenatal practices.

- Almost 16 percent of all girls under 15 having live births in 1994 had late (seventh-month or later) or no prenatal care. Among older teens, this figure was 8 percent.[181]
- Younger mothers (those aged 13 to 17) have poorer birth outcomes than older teens, even after adjusting for educational level and adequacy of prenatal care.[64]
- One study of pregnant and parenting teens revealed that 20 percent used alcohol after learning they were pregnant; 13 percent used other drugs.[27]
- Abused teens delay prenatal care more than nonabused teens: 24 percent of abused teens entered care in the third trimester, compared with 9 percent of nonabused teens.[129]
- Teen mothers are less likely to engage in breastfeeding than older mothers are. Teen mothers are sometimes discouraged from breastfeeding by partners who, although not necessarily physically violent, are controlling and verbally abusive. Some teens claim they don't nurse because their partner is jealous or unwilling to "share" with the baby.[117] An association has also been noted between the absence of breastfeeding and physical and sexual abuse of the mother and/or her children.[2]
- Pregnant teens not in school are almost twice as likely to have been abused as those still in school.[15]

The Public Health Service Expert Panel on the Content of Prenatal Care recommends that comprehensive service programs offering prenatal care, education, social services, parenting education, and other services should be provided to all pregnant women under 18 or 19, with priority given to those "least likely to be able to cope with pregnancy and parenting."[179] This includes younger teens, those from low-income or single-parent families, and those with low academic achievement. It would make sense to add those teens with a history of family or partner violence and to include violence prevention education in the program components.

What Practitioners Can Do:

- **Train providers in an array of services for pregnant teens to recognize and respond to the signs of abuse. (See the Alaska Domestic Violence Training Project, p. 28.)**
- **Include a history of violence as a criterion for entrance into programs for high-risk pregnancies.**
- **Provide additional support to young mothers whose partners oppose breastfeeding.**

Who Are the Fathers?

Reaching the partners of adolescent girls is important not only to help prevent pregnancy but also to prevent or stop abuse. This effort is made more difficult by the fact that many partners are considerably older than the teen mothers:

- The National Maternal and Infant Health Survey reveals that fathers are typically older than mothers, especially when the mothers are teenagers (age 15 or older). Half of the fathers of babies born to girls ages 15 to 17 are 20 years or older.[92]
- Adult, postschool men in one study fathered two-thirds of the infants born to mothers who were 18 years old or younger. Thirteen percent of the fathers were at least 25 years old.[98]
- Among 38,000 10-14-year-olds who gave birth from 1983 to 1986, 30 percent of the girls provided information about the age of the father. Of those, 70 percent of white girls and 42 percent of black girls reported that the father was 18 or older.[94]
- California and Maryland reported fathers' ages in 80 percent of the births among mothers ages 10 to 15 in 1994. In both states, only 8 percent of the fathers were peers of these girls; 43 and 57 percent, respectively, were ages 16 to 18; 43 and 31 percent were 19 to 24; and 6 and 4 percent were 25 or older.[96]

This age discrepancy is significant because these young girls generally have less knowledge, experience, and power than their partners and are therefore at greater risk for abuse in their relationships.[163] Additionally, the closer in age the baby's father is to the mother, the more likely she is to get adequate prenatal care.[40]

> On February 29, a 15-year-old girl was shot to death as she sat in a school bus on her way to school. Efforts to save her six-month-old fetus were unsuccessful. Family and friends said she had never confided to them who had fathered her baby. On June 2, a 29-year-old next-door neighbor was charged with having paid a 21-year-old male to kill the girl. The neighbor was the father of her baby as well as of two other children.
>
> —St. Louis, Missouri, 1996

The age difference is also relevant because these older fathers are generally not in school with the young mothers. Although this situation holds out an opportunity for reaching the girls independently of their babies' fathers, it also indicates that school-based services cannot reach these men. And as one writer points out, "There are serious philosophical and practical drawbacks to basing prevention strategy on the training of school-aged individuals when in reality these are adult behavior problems."[97]

What Practitioners Can Do:

- **Design school-based programs with these age discrepancies in mind.**
- **Develop services that address young adolescents in middle schools. Although school-based clinics are usually located only in high schools, most girls are menstruating and fertile at much younger ages.**
- **Educate pediatricians and others who serve young adolescent girls to be aware of the risks to these girls if they become involved with or abused by older males.**
- **Reach the older male partners of pregnant teens through community-based programs such as health clinics.**

Children Born to Teen Mothers Are at Increased Risk of Abuse

The correlation between abuse of a mother and abuse of her children has been well established. Although an extensive discussion of that link is beyond the scope of this guide, it is worth noting that this association is no less true for adolescent mothers.[27,110] A battered teen may not be able to negotiate protection for her child any more than she can for herself. Abused young women are more likely to have repeat pregnancies and pregnancies by different men.[27] This revolving door of relationships exposes the children to more men who have only marginal attachments to them.

> It is not only the absence of a father that harms a child, but the presence of a stream of men who move in and out of the life of her mother, behaving toward her with disdain or cruelty and mistreating her and her children.
>
> —*J.S. Musick*[117]

Children of adolescents are more likely to die from injuries and infections, as well as from violence,[166,185] and to have less medical care than children of adults.[101] Subsequent children born to teens tend to fare even worse than firstborn babies.[79] An abusive relationship exacerbates what are already significant psychosocial and health problems of these girls and their babies.

What Practitioners Can Do:

- **Provide opportunities to meet the needs of the mother and her children holistically through programs that collaboratively assess and respond to both domestic abuse and child abuse. (See the AWAKE materials, p. 51, and the Injury Prevention for Pregnant and Parenting Teens program, p. 36.)**
- **Train and support child protective services workers to recognize and respond to evidence of domestic violence as they investigate allegations of child abuse.**
- **Link services of child protection agencies and domestic violence programs to provide more comprehensive responses to families experiencing abuse. If one family member is identified as abused, others can be assessed as well.**
- **Offer support to new mothers through home visiting programs and provide them with parenting, injury prevention, and abuse prevention resources. (See the Injury Prevention for Pregnant and Parenting Teens program, p. 36, and the Elmhurst Hospital Center Maternal and Child Home Health Care program, p. 32.)**
- **Incorporate violence prevention and intervention components into health guidance and educational programs focusing on at-risk pregnant teens. (See Partners for a Safe Future, p. 38.)**

The Effects of Abuse on Pregnancy

What is known about the effects of abuse on pregnant women and their fetuses comes almost entirely from studies of adult women only. But there is little reason to believe that the situation is any better for battered pregnant teens; indeed, pregnant teens are already at increased risk of poorer prenatal care and birth outcome. The following summarizes what some of the research on violence against pregnant women has shown.

> The interrelationship of poor prenatal care, substance abuse, lack of support, and interpersonal violence is an important phenomenon to acknowledge when assessing and intervening during the pregnancy.
>
> —*Jacqueline Campbell* [34]

Victims Receive Inadequate Prenatal Care

Battered women appear to delay entry into prenatal care longer than nonbattered women[31,51,109] and to have fewer prenatal visits.[86] Since many studies of battered women have been conducted solely in prenatal settings for low-income women, this finding is confounded by the fact that poor women also frequently receive delayed care. Social isolation can also be a factor in lack of prenatal care. Pregnant battered women often have fewer social supports and less help from their families than other pregnant women do.[11,32]

In addition, batterers sometimes attempt to restrict the victim's access to medical care, including prenatal care. This may be part of an overall pattern of control or, more pragmatically, an effort to prevent her injuries from being recognized as the result of domestic violence.

Abuse Causes Negative Birth Outcomes

Because abuse is often found in a constellation of risk factors, it is difficult to isolate its effect. Nevertheless, clear relationships exist between abuse and negative birth outcomes. The batterer often directs his blows and kicks at the pregnant woman's breasts, abdomen, and genitals.[15,167] Adverse outcomes can include premature separation of the placenta, premature rupture of the membranes, and fetal death,[51,116,119,157,160] as well as:

- *Preterm labor.* Abused women have been found to be twice as likely as nonabused women to experience preterm labor. The rates are comparable with those reported in pregnant blunt trauma victims.[18]
- *Low birthweight.* Several authors have reported an association between abuse of the mother and low birthweight of the baby.[31,131,157] An association between sexual assault during pregnancy and low birthweight has also been noted.[155]
- *Miscarriages.* Spontaneous abortions are reported to be common among battered women, and the women themselves often attribute these pregnancy losses to beatings they have received.[84,157]

Substance Abuse Complicates the Situation

Pregnant victims of violence are more likely than other pregnant women to use alcohol and other drugs,[5,16,99] a factor that can jeopardize the health of their unborn babies as well as their own wellbeing. Victims' partners may also be more likely to use drugs.[5] Not only can it be difficult for a drug-dependent woman to leave an abuser (who may also be her supplier), but the presence of illegal substances in a relationship may add to her reluctance to turn to law enforcement officials for assistance.[17,18]

What Practitioners Can Do:

- **Assure the girl or woman that her own health and safety, not only her fetus's, are valued.**
- **Include routine and regular assessment of relationship violence within MCH programs and policies designed to improve birth outcomes. (See California's Comprehensive Perinatal Services Program, p. 30, and the Alaska Domestic Violence Training Project, p. 28.)**
- **Conduct research on the relationships between violence, reproductive health choices, and birth outcomes. (See Pregnancy Risk Assessment Monitoring System, p. 40, and Georgia Women's Health Survey, p. 34, as examples of programs seeking to improve surveillance on birth outcomes and on domestic violence during pregnancy.)**
- **Apply the successes and failures of campaigns to address alcohol and other drug abuse among pregnant women to the problem of physical abuse during pregnancy.**
- **Design programs to address multiple risks simultaneously. (See California's Adolescent Family Life Program, p. 46, a program designed to prevent and respond to both teen substance abuse and teen relationship violence.)**

Part II

Opportunities for Intervention

There are many ways in which MCH agencies and practitioners can translate the lessons of research into their ongoing practices and programs. Violence during pregnancy can be addressed by efforts to prevent teen pregnancies, to prevent violence against adolescents, and to prevent abuse of teens who are already pregnant. Violence against pregnant teens can be addressed through clinical care, within educational programs, by training providers, and by improving data collection and analysis. Promoting violence prevention and intervention messages through a variety of avenues, using diverse messengers, and directing messages at both young men and young women will help ensure the success of these endeavors.

Integrate Prevention and Intervention into Existing Services

Teens at risk of being battered and pregnant can be served in a host of public health settings, many of which are demonstrated by the programs described in Part IV of this guide. These potential settings include:

- family planning clinics
- adolescent health clinics, including those based in schools
- WIC clinics
- well-baby checkups
- immunization clinics
- prenatal and postnatal care settings
- prenatal and postpartum home visits
- HMOs
- women's health programs within state and local health departments
- adolescent health programs within health departments

Include Violence Prevention Screening in Prenatal and Other Settings

Clinics are particularly effective settings in which to reach teens, since adolescents tend to use these services more than older women do, perhaps due in part to concerns about confidentiality.[186] Counseling a teen about her options in an abusive situation should be as routine a part of prenatal care as recommending folic acid. The Surgeon General has called for routine violence screening during prenatal assessments.[177] The U.S. Preventive Services Task Force states: "There is insufficient evidence to recommend for or against the use of specific screening instruments for family violence, but including a few direct questions about abuse (physical violence or forced sexual activity) as part of the routine history in adult patients may be recommended on other grounds . . . Injured pregnant women . . . should receive special consideration for this problem."[180]

Screening cannot become fully effective until it is institutionalized within a setting.[112] Unless a heightened awareness of violence prevention becomes an integral part of a program, there is the risk that providers will forget to ask, that interest will dwindle under the pressure of competing demands, and that domestic violence will continue to be the "hidden epidemic." Reminder messages on posters, buttons, and stickers can be helpful in the early stages of a protocol, but ultimately the messages must be ubiquitous and standardized. For example, one emergency department found that stamping a question on the medical records as a prompt for the screener was more effective than provider education alone; the department has now added the question to the permanent record.[127]

Most existing studies and protocols have been implemented in only two types of settings: emergency departments and prenatal clinics. There are compelling reasons to expand prevention efforts beyond these two locations. Although emergency rooms have often been cited as a point of entry into the medical care system at which women at risk of domestic abuse can be readily identified and offered assistance,[50,75,88,111,178] they are not an ideal site for primary prevention of abuse during pregnancy. Emergency departments without protocols and training in place do a poor job of documenting injury and identifying abuse.[150] They have been noted

for both a failure to screen for or detect pregnancy[56,72,169] and a lack of privacy. Emergency departments receive most domestic violence victims between the hours of 11:00 p.m. and 7:00 a.m., when social work staff and support are least available.[127,144] Finally, undue emphasis on the emergency room as the primary screening site fails to recognize that this intervention comes only after serious harm has been done.

In addition, if programs limit domestic violence screening to prenatal settings, they will undoubtedly miss opportunities to "catch" teens who are at risk. Prevention messages need to be promoted long before a need for prenatal care arises. By establishing protocols for providing violence prevention information to patients in every available setting that serves adolescents, the chances are greatly increased that providers can intervene earlier, more comprehensively, and with greater effectiveness.

- **Incorporate screening and intervention for domestic violence into routine practice for perinatal care throughout the spectrum of MCH settings.**
- **Add a family violence screen to the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program.**
- **Include pregnant adolescents as a target population to be served within domestic violence programs.**
- **Strengthen violence prevention, screening, and intervention efforts within adolescent health programs.**
- **Include goals and objectives for reducing abuse of adolescents in general, and pregnant teens specifically, within strategic plans for violence and injury prevention programs.**

Reach Out to Young Men

There need to be many more materials and educational interventions directed at young fathers and at young men before they become parents. Chen points out that there is an "important role of adolescent fathers in achieving adequate prenatal care for adolescent mothers"[40] and suggests parenting classes and other services for these fathers. Dating violence programs and education can be incorporated into schools, teen programs, STD clinics, parent education programs, and other activities that reach adolescent and preadolescent males. (See Resources in Part V for examples of dating violence curricula.) A study of male high school students found that those who had caused a pregnancy were more likely to have been injured in a fight, to drink alcohol while driving, and to have had multiple sexual partners during the previous 30 days. They also had an increased lifetime frequency of alcohol and cocaine use.[165] Programs that address these concurrent risks among young men can be designed to incorporate information on pregnancy prevention and on conflict resolution.

- **Develop and expand prevention programs directed at male adolescents.**

Teen Pregnancy Prevention and Parenting Programs

Pregnancy prevention and parenting programs for adolescents offer excellent opportunities to uncover cases of sexual abuse among pregnant teens, to address violent relationships within teens' lives, and to prevent child abuse to the babies of teen mothers. A recent compilation of programs focusing on adolescent pregnancy prevention (many of them also serving pregnant and parenting teens) includes 11 projects that identify violence or abuse as topics they explicitly address (see Healthy Mothers, Healthy Babies, p. 52).

Pregnancy prevention programs can provide violence prevention counseling as part of the preconception counseling that has been recommended by the Public Health Service's Expert Panel on Prenatal Care[179] and by the Healthy People 2000 guidelines.[177]

Home Visiting Services

Home visitors can identify pregnant and postpartum teens at risk of abuse by assessing their relationships, the use of alcohol and other drugs in the home, the presence of a weapon, any history of abuse, and so forth.[11,126] Olds has shown that home visiting can be an effective intervention in reducing child abuse and neglect.[126] Home visiting also holds the promise of identifying the potential for violence against the young mother. Home visiting programs teach parenting skills to inexperienced parents and often conduct home safety checks to identify hazards and risks to young children (see the Elmhurst Hospital Center Maternal and Child Home Health Care Program, p. 32, and Injury Prevention for Pregnant and Parenting Teens program, p. 36).

Various MCH Providers Can Help

Throughout the spectrum of maternal and child health practice are many professionals who can assist in violence prevention and intervention activities:

- *Nurse-midwives.* Women with a previous history of abuse are represented in the caseloads of nurse-midwives in greater numbers than they are in those of physicians.[154] In addition, the American College of Nurse-Midwives is offering a *Domestic Violence Education Module* to nurse-midwife students (see p. 51).

- *Nurses and social workers.* A study in West Virginia found that more than three-quarters of the women experiencing violence during pregnancy had been missed during standard prenatal risk assessments; interviewing by nursing and social work staff yielded many more disclosures.[51] (See the March of Dimes nursing module, p. 26, and a public health nursing protocol, p. 54.)

- *Prenatal care providers.* Pregnant teens who seek prenatal care are engaged in regular contact with the health care system; ideally, they are able to receive a steady supply of intervention messages and to have the opportunity to reveal their abuse to a caring listener.

- *Pediatricians.* These physicians have been urged to incorporate interconception care into their anticipatory guidance activities.[90] Violence prevention counseling fits well within this framework.

- *Home visitors.* Public health nurses are more likely than other practitioners to encounter abused victims by visiting "isolated women in the home who are inadequately receiving prenatal care services" and are thus in a unique position to offer counseling and support.[14]

- **Address domestic violence in the contexts of teen pregnancy prevention, prenatal care, and adolescent health through training workshops and materials such as newsletters, fact sheets, and videos.**

Get the Word Out

Information about abuse (risk factors, warning signs, options for the victim) can be presented through posters, brochures, and other means in waiting rooms, women's restrooms, changing rooms, and other public and private settings. Within the community, posters and written information can be distributed in hair salons, laundromats, children's clothing stores, daycare centers, high schools, child safety seat distribution programs, and other settings where young mothers are likely to go.

Educational information can also be presented to local health departments through manuals, directories, and other materials useful in clinical care settings. A number of examples are in the Resources section, Part V.

- **Provide information to adolescents at risk, to their families, and to the agencies that serve them.**
- **Develop materials to help parents cope with a teen pregnancy within their own families.**

- **Develop and disseminate to patients and clients materials that overtly address domestic violence and pregnancy.**
- **Update and expand existing materials to reach an adolescent audience. (See Part V for resources.)**

Enhance Documentation and Surveillance

Good, complete documentation within the medical record can lead to improved coding. By providing adequate documentation on the nature, cause, and mechanism of the injury in the chart, health practitioners can assist records coders in selecting specific N (diagnosis) and E (external cause of injury) codes that will result in better data collection, enhanced research, and improved prevention efforts. An examination of emergency room data found that rates of falls were highest among 25- to 34-year-old women;[74] such high rates raise the suspicions that some injuries from assaults were presented by patients—and accepted by providers—as "accidents." Local programs can analyze their own data with an eye to discrepancies that might reveal undisclosed violence.

- **Develop surveillance programs and use data to target prevention efforts.**
- **Use child death review teams and maternal mortality review teams to examine adolescent girls' deaths that may be linked to pregnancy and/or an abusive partner.**

Improve and Increase Training of Providers

Insufficient training of providers about domestic violence contributes to the gap between policy and practice; perceptions of some health care providers that domestic violence is not a problem for them and their patients or that it is a private matter not conducive to health care counseling also form barriers to improved practice.[58,134,173,175]

The inadequacy of medical education on domestic violence has been noted by numerous authors,[14,37,134,156,175] although this situation is improving.[61] Continuing education can help providers enhance and renew their knowledge base. A number of nursing modules on domestic violence are available (see Resources in Part V for materials produced by the American College of Nurse-Midwives, American College of Obstetricians and Gynecologists, March of Dimes, Oregon Public Health Association, and Pennsylvania Medical Society). Health department staff and others can be trained about the links between unintended pregnancy and domestic violence and about ways in which both issues can be addressed (see the Alaska Domestic Violence Training Project, p. 28).

- **Very little domestic violence training focuses on the particular issues that affect abused adolescents. Their special concerns and needs must be taken into account, and information on mandatory reporting and legal issues involving minors must be included.**
- **Integrate the topic of abuse against pregnant teens into existing training and continuing education opportunities.**
- **Conduct professional training about violence and teen pregnancy at schools of public health and schools of nursing.**

Training must also take into account the fact that domestic violence occurs not only to patients but also to providers. When violence prevention programs and campaigns are initiated within an institution, personal history and experiences need to be recognized. In a recent survey, 12.6 percent of medical faculty and students reported abuse by a partner during their adult lives.[47] Some practitioners may have strong personal reasons to be opposed to or uncomfortable with raising these issues with their clients. The climate of safety must extend to employees throughout the organization, as well as to clients.

Collaborate with Other Services and Agencies

Clients may frequently need referrals to additional services, including medical care, counseling, hotlines, shelters, support groups, patient advocates, law enforcement, legal advocacy, and victim assistance programs. In many states, local battered women's coalitions have produced resource guides to aid in making referrals. In addition, the new National Domestic Violence Hotline provides a nationwide, toll-free, 24-hour referral and counseling service. All practitioners should be aware of this resource: 800-799-SAFE. Local hotlines are also available in some areas of the country.

Services for Teens May Not Be Available, Accessible, or Adequate

Referrals for teens require special consideration. Some battered women's shelters are unable to accept unemancipated minors—teenagers still legally under the guardianship of an adult. On the other hand, shelters for teens may not always be able to accommodate late-trimester girls or their infants.[141] Providers need to know whether domestic violence shelters in their community accept unemancipated minors and whether teen shelters will admit an adolescent in late pregnancy or with a baby.

The adolescent may also have concerns that, as a minor, her confidentiality will not be maintained and an extra effort may need to be made to assure her of privacy and respect. Providers will also need to be knowledgeable about child abuse laws in their states in order to respond appropriately to disclosure of abuse at the hands of family members. (See p. 23 for a model flow chart of decision making with battered pregnant teens.)

Adolescents may not be old enough to drive or have access to a vehicle. Transportation and financial problems can limit the teen's ability to participate in those programs that are available. Programs designed to reach younger teens may need to provide transportation options for participants.

Collaborate for Comprehensive Solutions

Multidisciplinary collaborations can strengthen programs, task forces and training opportunities. Programs providing collaborative care have shown promising results with their clients.[75,128] Multidisciplinary task forces to address domestic violence have been successfully formed by hospitals, community agencies, and other organizations. MCH practitioners can play a key role in such task forces, along with other medical and mental health providers; other violence prevention practitioners; domestic violence service providers; law enforcement and judicial professionals; women's advocates; educational, religious, and political leaders; survivors of violence, including adolescents; and other interested persons. The MCH practitioner in particular can bring the unique concerns of pregnant teens to the attention of the task force and can advocate for primary prevention as well as adequate response. Finally, training should incorporate providers at all levels within an agency, from security guards to receptionists to lab workers. (See Neponset Health Center's *Community Health Center Domestic Violence Protocols*, p. 54, as an example.)

- **Develop a strategic plan with other agencies that serve teens, such as violence prevention programs, law enforcement agencies, shelters, and educational systems, to form multidisciplinary, multijurisdictional programs.**
- **Work with other programs that serve the children of teen mothers, such as WIC, Head Start, daycare providers, and child safety seat distribution programs.**
- **Cooperate with local agencies to ensure the availability of adequate shelter resources in the community for pregnant and parenting minors.**
- **Explore opportunities to jointly promote prevention messages to the general public as well as to other practitioners.**

Expand Research to Improve Knowledge

Despite the size of the bibliography in this guide, only a handful of studies have actually focused on violence during pregnancy and even fewer on the pregnant teen population. Too many of the existing studies have focused on low-income women using prenatal clinics, thus missing adolescents, women who chose abortion, and women who sought prenatal care through private settings. A lack of uniform definitions and measurements makes it difficult to compare existing studies with one another. Further research is needed in several critical areas:

- *Miscarriages*. Most studies have eliminated women who miscarried, aborted, or had stillborn babies. We must rely heavily on anecdotal reporting of miscarriage linked to violence, possibly underestimating both the rates of miscarriage caused by abuse and the overall rates of violence during pregnancy.

- *Delayed prenatal care*. Research shows that battered women tend to enter prenatal care later than is recommended. But we do not yet know whether women who have postponed prenatal care for reasons other than abuse end up victimized during the postpartum period. In other words, is delayed care a red flag for an increased risk of postpartum abuse, even if the woman has not been battered before or during pregnancy?

- *Maternal mortality due to violence*. Most studies of maternal mortality focus on pregnancy-related complications and have excluded those deaths attributable to injury, and death certificates often fail to indicate whether the deceased woman was pregnant.[60,147] Studies conducted to discover death rates due to injuries among pregnant and postpartum women have found rates of 34 to 46 percent. A large proportion of these deaths are homicides.[45,48,174] Improved reporting of pregnancy on death certificates would help establish a more accurate picture of maternal mortality.

- *Population-based studies*. As a recent review noted, "Research must also address whether the pattern of violence changes during pregnancy—a basic research question that we cannot accurately determine from existing studies."[66] A population-based surveillance system would go a long way toward answering some of the questions that still confront us.[149]

- Other suggestions for future directions include surveys of current counseling practices in diverse settings to see whether battering during pregnancy is adequately addressed, a synthesis of current information drawn from studies of batterers of pregnant teens and women, and improved evaluation of prevention programs.

In recent months, many new journal articles on battering during pregnancy have been published. National television talk shows have occasionally addressed the topic of battering of pregnant women and teens. The federally funded National Domestic Violence Hotline has opened, providing another avenue that women can use for assistance. New programs and initiatives are being introduced and evaluated. All these activities provide new opportunities to communicate key prevention and response messages to and about adolescents. In addition, the lessons being learned from more general violence prevention programs—whether reducing access to firearms, addressing media images of violence against women, or providing adolescents with nonviolent alternatives to conflict—can also be applied to the specific populations of pregnant and battered teens.

The tools and techniques in Part III of this guide can help practitioners screen for abuse, provide referrals, and present options to abused teens. The programs described in Part IV present examples of how local and state agencies are actively responding to the possibility of violence in the lives of pregnant women and teens.

Part III

Toolkit

Tools and Techniques for Clinicians

Numerous manuals, videos, curricula, trainings, and documents assist providers in learning how best to screen for violence against women. The text that follows is not a substitute for a thorough training but does include several basic elements that need to be considered when serving pregnant teens. The most widely referenced tools are included within many of the resources listed in Part V. These are:

- *Abuse Assessment Screen (AAS),* designed by the Nursing Research Consortium on Violence and Abuse.[95,104,109,122,130,132] The AAS consists of five questions that ask about frequency and severity of physical, emotional, and sexual abuse; relationship of the abuser; and body sites of injury. One question is specifically for pregnant women.

- *Danger Assessment Scale* (also called *Lethality Assessment),* designed by Jacqueline Campbell,[32,108,129,130] is used to determine the potential danger of homicide in an abusive relationship. It contains 15 questions regarding frequency and severity of violence, control and threats, partner use of alcohol and drugs, presence of a firearm, suicide threats and attempts, and violence during pregnancy. The instrument includes a calendar on which the client can record past incidents of abuse in order to gauge changes in frequency and severity. Unchecked abuse often escalates; this scale helps both provider and client see whether the abuse is intensifying.

- *Body maps* are simple outline diagrams of the female body.[81,132] The patient is asked to mark or otherwise indicate on the map the locations where she has been hurt. This then becomes part of her medical record. The body map is particularly useful for documenting prior assaults of which there are no current marks, or current assaults that have left no visible sign, and can also be used in nonmedical settings.

- *Safety plans* are used to help clients figure out their options and ensure that they have the items and resources they need.[8,29] They include a list of important items for the abused woman to take with her when leaving a violent household (keys, birth certificates and other documents, health information, etc.). There is room for her to record the names and phone numbers of friends, relatives, and professionals who can assist her with money, housing, and emotional and social support. Some safety plans include information on planning an escape route and considerations for daycare and work routines.

Use of tools such as the Danger Assessment, together with body maps and other documentation of abuse, can be valuable in civil and criminal court proceedings. These instruments are also important teaching tools for clients and providers and can help the provider in counseling and referring the teen for additional assistance.

What to Look For

There are many potential signs of abuse among pregnant girls. Some of the more frequently observed cues are:

- injuries to the face, breasts, genitals, and abdomen
- injuries to the hands and forearms (from warding off blows)
- old injuries, such as bruises, burns, and fractures
- delays in seeking care for injuries
- injuries inconsistent with the offered explanation
- late or sporadic prenatal care and frequently missed prenatal appointments
- a partner or family member who answers for the teen or refuses to let her be seen alone
- a history of STDs and pelvic inflammatory disease
- depression
- evidence of sexual assault

Practitioners should document the teen's injuries and other evidence of abuse carefully with body maps, photographs, and narrative description so that her medical record is complete. This documentation can be used as evidence should she decide to pursue the matter in court and also gives future providers important information for her care.

How to Ask and Respond

Many domestic violence protocols suggest using direct questions, such as "Has a partner ever hit, kicked, or otherwise hurt or threatened you?" Others suggest something like "Violence is a common event in the lives of many of my clients. Is anyone in your life hurting you?" Screening and counseling for adolescents need to be open-ended enough to allow for unexpected and multiple answers. Ask specifically whether anyone else, besides the partner, has hurt the adolescent. Too much emphasis on a boyfriend may exclude disclosure of abuse by family members or others. (See Violence and Substance Abuse Prevention Project, p. 46, as an example of a program that is developing adolescent-specific screening tools.)

> Have you ever been frightened by violent or sexual things someone has said to you? Have you ever witnessed violence? Been threatened with violence? Been a victim of violence? Has anyone ever tried to harm you physically?
>
> —*Questions for adolescents*[73]

Many teens will not feel comfortable disclosing abuse at the first opportunity. As ACOG states in its most recent campaign materials, "Talking about abuse isn't easy. You may not be ready today. When you are, we're here to listen" (see ACOG, p. 51). Some nurses report stimulating more disclosure when they use a structured screening instrument[122] while others recommend a more open-ended approach.[119] Use of either approach may depend in part on the practitioner's own comfort level and experience with broaching the subject.

MCH practitioners may counsel a teen directly about her options and may refer her to other services. Domestic violence advocates recommend that when counseling, providers listen and ask questions in a nonjudgmental way, acknowledge the adolescent's feelings, and remind her that she does not deserve this treatment. Provide her with referrals and information on legal options (calling the police, pressing charges, taking out restraining orders, etc.). (See March of Dimes flow chart, p. 23.) Restraining orders should include the teen's home, school, and workplace in order to provide her with more complete protection.

It is important to express care and concern for the pregnant girl herself, not solely for her baby. As Sorenson and Saftlas state, "Views of violence against women often are cast in terms of how it puts *others* at risk (e.g., the police officers who intervene to try to stop it, the children who witness it, or the fetuses who abort because of it) rather than in terms of the danger to the woman."[164]

Issues to Address

Ask about Past Abuse

Remember, the strongest predictor for future abuse is a history of abuse. If the adolescent has been beaten before becoming pregnant, she may well be at risk again.

Include Sexual Abuse in Your Agency's Definition of Abuse

Studies of marital rape and domestic violence have found that 40 to 45 percent of battered women are also forced to engage in unwanted sexual activities.[34,109] Pregnant women are not immune to these assaults;[155] indeed, sexual assault cannot be completely separated from domestic violence. (This connection is starkly shown by a recent study that asked women infected with HIV what happened when they revealed that they had contracted the virus. Some of the partners responded by beating and raping them.[145]) And, as we have already seen, sexual abuse is often a precursor to premature pregnancy among adolescents.

Ask Whether the Teen Needs Help Disclosing Her Pregnancy

Caregivers responsible for providing pregnancy test results to teens should ask whether the girls need assistance in sharing this news with their partner or guardian. Elements of a safety plan can be incorporated into the disclosure, if needed.

Ask Whether the Abuse Has Been Escalating

Are the incidents becoming more frequent? More severe? Are the threats becoming more explicit or more violent? Is the batterer threatening to commit suicide? Use the Danger Assessment to assist with these questions.

Ask about Weapons

The presence of a firearm adds to the jeopardy in which an abused woman or girl lives. A number of states and localities have recognized and responded to this hazard by confiscating firearms from defendants who are under restraining orders or orders of protection. The National Council of Juvenile and Family Court Judges has recommended that protection order codes include "an order prohibiting the defendant from possessing any firearm or other weapon specified by the court,"[78] and in 1994 the federal Crime Bill prohibited persons under restraining orders for domestic abuse from purchasing or possessing firearms. However, most persons *convicted* of domestic violence are not restricted from firearm possession.

- **Has the adolescent ever been threatened with a weapon?**
  Is there a firearm in her home?
  Does the abuser have a firearm?

Home visiting programs can assess whether there is a firearm in the home and provide appropriate anticipatory guidance for all family members. Pediatric and well-baby visits can address the risks of firearms in the home to children. For instance, the American Academy of Pediatrics now distributes "Gun-in-Home" stickers to place on the child's medical chart if a firearm is present; these remind pediatricians to deliver firearm safety messages during all health visits. In addition, safety plans and assessments for abuse should explicitly address whether the abuser has access to a firearm and what the woman's legal options are. (See Injury Prevention for Pregnant and Parenting Teens program, p. 36, as an example of a program that screens for firearms in the home.)

Understand Her Reasons to Stay or Leave

Pregnancy is a time when some women want to stay connected with their partners, despite the abuse, while others will be motivated to leave. Shelter workers have noted that residents will often express the desire to reconcile so that the baby will know its father. In addition, financial, social, emotional, or familial interests may give her a strong incentive to stay in the relationship. However, the risks of abuse to her pregnancy can also motivate a woman to leave in order to protect her unborn child. Counselors and providers can help present the pregnant teen with a clear understanding of her situation, the risks she confronts, and the options available to her so that she can make an informed decision.

> I guess what helped me make my decision was the night I left, he came very close to slicing my throat with a knife . . . Also I was going for a pregnancy test the next day. He had punched me in the abdomen about three months earlier, causing me to miscarry. The night I left, I was so scared that he would make me lose another baby, I had to leave.
>
> –Anonymous Internet posting, February 7, 1996

> He hit her hard, sent her to the hospital more than once, including when she was pregnant with Jessica. "That's when I decided to leave him," she said. "I thought it would be a shame to lose a baby over a man."
>
> –*Boston Globe*, April 20, 1995

When to Ask

Ask *several times*, in different trimesters, if possible. Many of the available statistics on rates of violence during pregnancy were derived from studies in which the women were asked only once during the course of pregnancy. In programs that screened the women more than once, the rates were even higher.[34,109] By making these questions a routine and regular part of care, both provider and client will become more comfortable with the subject and with each other. An atmosphere of trust helps teens talk about difficult subjects. Finally, multiple screenings allow for a more rapid response to any initiation of abuse. (See California's Comprehensive Perinatal Services Program, p. 30, which urges providers to screen each trimester and during the postpartum exam.)

A fourfold approach is needed:

1. *All patients*, not simply those presenting with injuries, need to be screened *at some time* for violent victimization. Routine screening not only increases the chances of assisting victims but also alerts all women to the possibility of abuse. In addition, it allows time for a relationship of trust to be built with a provider.

2. *Pregnant girls and women* need to be screened *regularly* for abuse as part of their ongoing prenatal care. Screening tools and protocols, when consistently used, can help providers incorporate violence screening, counseling, and referral into their day-to-day practice.

3. *Victims of abuse* need to be screened and tested for *pregnancy*. Too often, the pregnancy goes undetected, leading to delayed prenatal care and other health risks.

4. Finally, a *history of abuse* should be recognized as a risk factor for current or future abuse.

Screening for Pregnancy

Keep in mind that many pregnant teens deny or are unaware that they are pregnant. The question "Are you sexually active?" may be too vague for some girls, and many teenagers may not know or admit that they are pregnant. A study of teens diagnosed as pregnant while in the emergency department found that fewer than 10 percent mentioned the possibility of pregnancy initially, and 10.5 percent denied being sexually active at all.[36] A similar study found 10 percent of girls who tested positively for pregnancy denying sexual activity.[72] It is not known whether this denial is based on ignorance, embarrassment, unwillingness to tell a health provider, or some combination of factors.

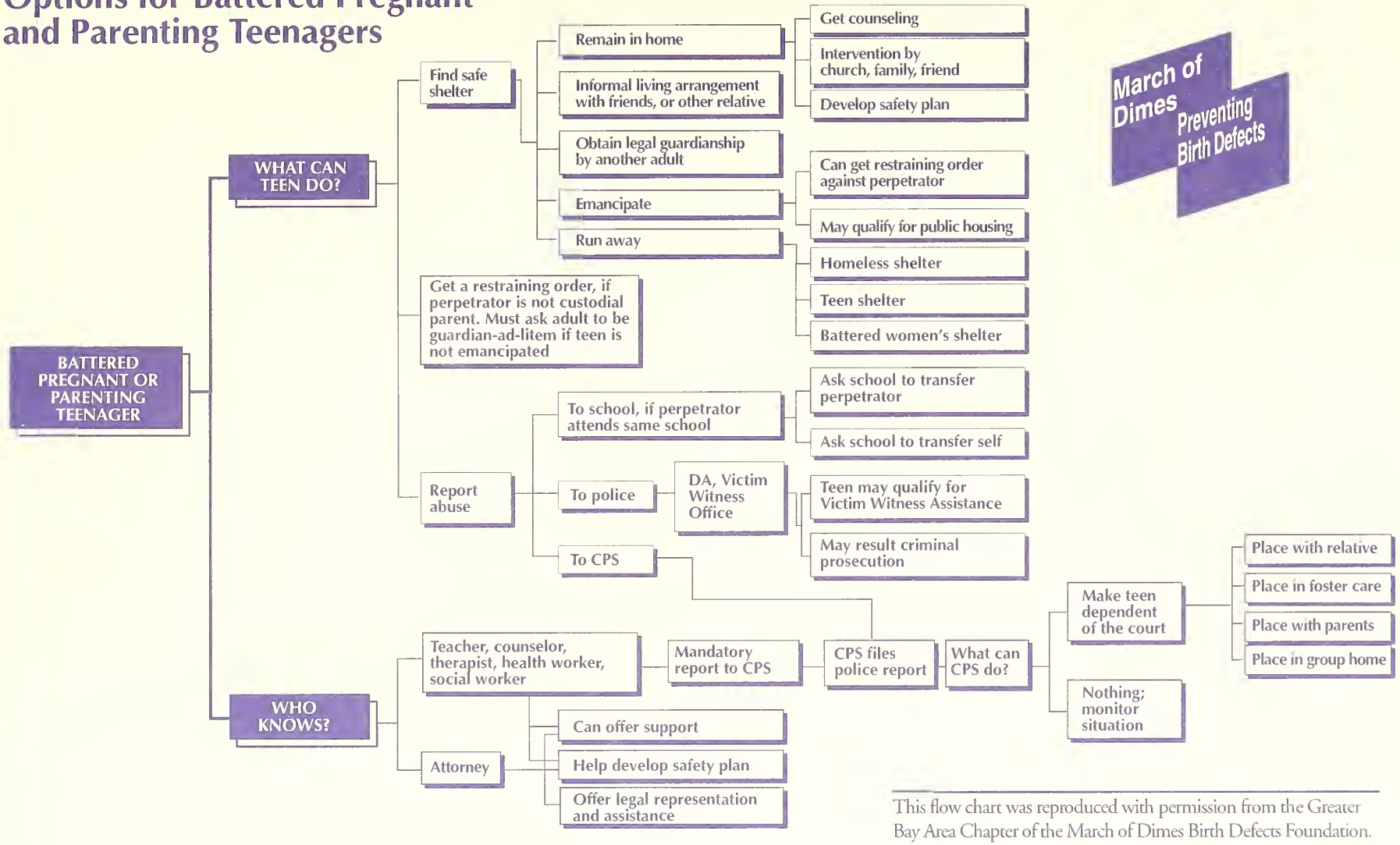
On the other hand, more than a third of adolescent girls who tested negative for pregnancy were "quite certain" they were pregnant.[186] Together, these studies underscore that young girls and women may not be familiar enough with their own bodies or with the facts of reproduction to recognize the signs and symptoms of pregnancy or perhaps even the behaviors that can place them at risk of conception.

Teens often delay testing for pregnancy if they suspect they might have a positive result. Psychological barriers, particularly difficulty in acknowledging the pregnancy, were named in one study as the most important factors in why teens delayed testing.[24] Procrastination leads to delayed decision-making and late entry into prenatal care.

A Flow Chart of Options

The flow chart on the next page, developed by the Prevention of Battering During Teen Pregnancy Project of the Greater Bay Area Chapter of the March of Dimes, provides a useful model for helping a battered pregnant or parenting teen identify her options.

Options for Battered Pregnant and Parenting Teenagers



This flow chart was reproduced with permission from the Greater Bay Area Chapter of the March of Dimes Birth Defects Foundation. The original flow chart contains detailed California-specific footnotes. (See p. 44 for a description of the Prevention of Battering During Teen Pregnancy Project and information on obtaining the complete flow chart and other resources.)

Part IV

Programs

This section describes a dozen projects working to address the problem of violence against pregnant teens. Project activities include surveillance, prevention, intervention, training, systems change, public awareness, and development of materials for screening, response, safety planning, and referral. These activities take place in a variety of settings, including state and local health departments, home visiting programs, HMOs, community health centers, provider trainings, WIC clinics, case management programs, and teen shelters.

Most of these programs represent direct service settings that provide unique opportunities to identify teens at risk of violence and to intervene and prevent further harm. Two projects focus on training health care providers to recognize and respond to violence during pregnancy, and several other projects incorporate provider training and/or staff education. Several surveillance projects are also included to illustrate ways that data about pregnancy-related violence are being obtained and to demonstrate how questions on the topic can be integrated into broader surveillance on health issues affecting women and adolescent girls. For those programs that include an evaluation component, the evaluation is described briefly.

We encourage you to consider how some of these approaches can be incorporated into your own practice setting. Each of these programs is willing to share its experiences and resources with MCH practitioners interested in developing similar programs or integrating elements of these projects into their own work. Many projects have published materials available and will share various screening instruments, assessment forms, data, and other resources with interested professionals. Contact information is provided for each project.

The March of Dimes *Abuse During Pregnancy* nursing module was developed to increase nurses' awareness and action around domestic violence and pregnancy. This module contains research documentation and clinical protocols of care to enable health care providers to assist women in preventing abuse, to interrupt existing abuse, and to protect the safety and well-being of pregnant women and adolescents. It is a national prototype for educating providers about domestic violence during pregnancy and training them in effective assessment and intervention.

Target Audience
Registered nurses and other health care professionals working with pregnant women of all ages

Abuse During Pregnancy: A Protocol for Prevention and Intervention

March of Dimes Birth Defects Foundation Nursing Module

✔ training for nurses and other health care providers

✔ assessment and intervention tools

Description

The goal of the March of Dimes nursing modules is to provide practitioners with continuing education and up-to-date information to enhance their basic skills. *Abuse During Pregnancy: A Protocol for Prevention and Intervention* was written in 1994 by Dr. Judith McFarlane and Dr. Barbara Parker, each of whom has a long history of applied research in the field of domestic violence.

The module is organized to help providers understand and apply the following key concepts:

1. Abuse of pregnant women is common and associated with maternal complications and lower infant birthweights.

2. A protocol of abuse assessment and intervention is essential during each prenatal visit.

3. A safety plan and community resource options can protect the safety of all pregnant women and interrupt the cycle of abuse.

The module also specifies practice objectives for those who complete the program. Upon completion, each participant can be expected to assess pregnant women for abuse, develop a safety plan with each abused woman, help abused women identify their options, develop a plan for continued follow-up and support for abused women, and use community resources to make appropriate referrals for protecting the safety and preventing the further abuse of pregnant women.

The module begins by summarizing recent research on abuse during pregnancy. It then guides learners through a clinical protocol on domestic violence prevention and response. In the first phase, providers are asked to examine their own feelings and beliefs about abuse. They are then walked through the steps of how, when, and where to conduct abuse assessments and interventions. Providers are encouraged to use this protocol in clinical practice and other settings such as childbirth education classes.

Providers also benefit from the practical tips for addressing difficult issues, such as how to ask key questions without offending patients and how to tactfully separate a woman from a possibly abusive partner while they are visiting the clinic. In addition, abuse awareness, assessment, and intervention tools are provided throughout the module, either for duplication or to serve

as templates for developing new materials; many are in both English and Spanish. Included in the module are the Abuse Assessment Screen, developed by the Nursing Research Consortium on Violence and Abuse, and the Danger Assessment, developed by Jacqueline Campbell. Vignettes of survivors' experiences are also included throughout the document to illustrate the complexity of the problem and to elicit discussion.

Concerns particular to the battered pregnant teen are raised in a section entitled "Special Considerations for Working with Teens." This section discusses potential parental pressure to stay in a relationship, how teens may feel a need to stay with the abuser to ensure financial support for the baby, and the social pressures teens may feel to remain in a dating relationship.

Registered nurses are eligible for continuing education credits, which can be obtained after successful completion of the module through participation in one of three learning formats: independent study, group-facilitated session, or continuing education conference. The March of Dimes is accredited by the New York State Nurses Association and the California Board of Registered Nursing; this module is also approved by the American College of Nurse-Midwives for contact hours.

The March of Dimes has also developed a videotape aimed at health care providers who work with pregnant women: *Crimes Against the Future*, a 23-minute video developed in 1989, provides an overview of the problem of battering during pregnancy, including interviews with both survivors and abusers, as well as some beginning tools for assessment and intervention.

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Professional Education Specialist

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Available Materials

Abuse During Pregnancy: A Protocol for Prevention and Intervention is available for $15 (discounts are available for large orders); *Crimes Against the Future* is available for $75.

Funding

The March of Dimes Birth Defects Foundation funded the development of this nursing module.

With a focus on linking health care providers with social service providers, the Alaska Domestic Violence Training Project aims to create community-based training teams that take a multidisciplinary approach to the problem of domestic violence. Combining intensive train-the-trainer sessions with ongoing technical support, this project helps health care professionals recognize and respond to domestic violence and educate their peers about the issue. The project also seeks to reach the diverse Alaskan population and address the particular needs of individuals in the isolated rural regions of the state. In addition, the project has developed a specialized training module on domestic violence during pregnancy.

The Alaska Domestic Violence Training Project

Alaska Department of Health and Social Services, Section of Maternal, Child, and Family Health

- ✔ training for health care providers
- ✔ linking health care providers with social service providers
- ✔ special module on domestic violence during pregnancy

Description

In 1993, the Alaska Department of Health and Social Services received a one-time grant to conduct a statewide domestic violence training needs assessment of health care providers. More than 700 health care providers—physicians, nurses, physicians' assistants, and nurse practitioners—were surveyed. The survey revealed that fewer than one-fourth of physicians had had any training about domestic violence in the previous two years. And while more than one-third of physicians estimated that 10 percent or more of their adult female patients had experienced abuse, the majority of the providers surveyed did not screen routinely at initial visits, annual visits, first prenatal visits, or follow-up prenatal visits.

The Alaska Domestic Violence Training Project (ADVTP) was developed in 1994 to address this demonstrated need by providing multidisciplinary training and support to health care and social service providers throughout the state. By linking health care professionals with experienced social service providers, the project aims to create networks of well-trained professionals who will continue to collaborate in grassroots initiatives beyond the scope of this project. Training topics include assessment, domestic violence indicators, intervention, referral, and documentation. Project staff are on call to provide training anywhere in the state, and programs may range from an on-site training for two rural physicians to a training at a community health clinic to a workshop at a large statewide health care conference.

In addition to on-site trainings upon request, ADVTP conducts train-the-trainer workshops. These workshops bring together teams of domestic violence shelter staff and at least two health care providers (who can include primary care physicians, OB-GYNs, nurses, health aides, dentists, mental health professionals, emergency medical technicians, etc.) from around the state. These teams then return to their communities to train other providers. All teams agree to lead at least two local trainings per year and to become domestic violence task force members in their communities. The workshops also provide time for health care providers to meet with local domestic violence program staff to discuss local needs and resources. ADVTP provides the teams with ongoing technical support, including speakers, training materials, and assistance in developing local workshops and seminars. The project also maintains a resource lending library and an 800 number for technical assistance requests.

Target Audience

Health care providers serving women and teens; all women, especially rural women in isolated areas

In response to state population-based data from the Pregnancy Risk Assessment Monitoring System (PRAMS; see description on p. 40) revealing that at least 15 percent of Alaskan women experience physical abuse around the time of pregnancy, the project has developed a specialized module on domestic violence during pregnancy. This module is targeted to prenatal care providers, including community health aides, family practice physicians, general practice physicians, OB-GYNs, and public health nurses. In addition, an overview on domestic violence and pregnancy is included in *all* trainings given by ADVTP, since emergency department physicians, dentists, and other health care providers are also likely to see pregnant patients who are being abused. The project plans to develop additional resource materials for health care providers on battering during pregnancy.

Other specialized training programs include a module for dentists on domestic violence and a module on domestic violence and child abuse.

In developing the different components of this project, ADVTP staff work closely with state and local provider coalitions and advocacy groups, including the Alaska Network on Domestic Violence and Sexual Assault and the Alaska Council on Domestic Violence and Sexual Assault. Ongoing training needs assessments of health care providers are conducted to ensure that training is responsive to providers' needs and to target and develop future training projects. The project has conducted statewide needs assessments for a wide range of provider types, including:

- primary care physicians
- nurse practitioners
- public health nurses
- physicians' assistants
- dentists
- dental hygienists
- X-ray technologists
- eye care specialists
- physical therapists
- emergency medical technicians
- community health aides
- health representatives

Trainings have been offered in varied settings, including community health clinics, WIC programs, battered women's shelters, health clinics for homeless individuals, and others.

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Available Materials

Training modules, diskette versions of slides and overheads, the *One in Five Women* health care provider handbook, and a report on health care provider practices for domestic violence are available to interested practitioners. Alaska residents can access the project's lending library of training materials, including videotapes, audiotapes, and books.

Funding

Primary funding for this project is a three-year grant from the federal MCHB. Additional funding is provided by the Johns Hopkins Injury Prevention Center and the Alaska Department of Health and Social Services.

California's Comprehensive Perinatal Services Program (CPSP) seeks to decrease the incidence of low birthweight in infants and to improve pregnancy outcomes of women receiving Medi-Cal services. Recognizing that abuse may begin during pregnancy and that pregnancy is often the only time healthy women come into frequent contact with health care providers, CPSP has developed tools to aid providers in recognizing and responding to abuse. This program illustrates the importance of integrating domestic violence screening and intervention into routine prenatal and postpartum care.

Domestic Violence Brief Intervention Model

California's Comprehensive Perinatal Services Program

- ✔ perinatal health care
- ✔ Medicaid recipients
- ✔ tools for health care providers

Description

Clients of California's Comprehensive Perinatal Services Program (CPSP) are pregnant and parenting women of all ages whose low incomes qualify them for Medi-Cal insurance (California's Medicaid program). CPSP offers Medi-Cal reimbursement to providers for obstetrical, nutritional, psychosocial, and health education services to women from conception through two months postpartum. CPSP-eligible providers, who must be certified by the California Department of Health Services, include physicians in private, individual, or group practices; certified nurse midwives; and county, community, and hospital clinics.

CPSP convened a Domestic Violence Task Force in 1994 to ensure that CPSP sites throughout the state have access to the information, resources, and training opportunities they need to identify and appropriately refer patients who are at risk for or currently being victimized by domestic violence. CPSP providers operate in a wide variety of settings and work with clients from many cultural and ethnic groups. For this reason, the task force developed the *Domestic Violence Brief Intervention Model,* which provides culturally competent screening and intervention tools that are adaptable for a range of perinatal health care environments.

The *Domestic Violence Brief Intervention Model* leads perinatal health care providers through the process of screening and assessing pregnant clients for domestic violence as a routine part of perinatal care. Significantly, the model specifies that CPSP providers and their staff screen *all* pregnant clients for domestic violence during *each* of the three trimesters—even if no indicators of abuse were revealed during previous visits—as well as at the postpartum visit.

Rather than "reinvent the wheel," the task force collected assessment and intervention materials from around the country and tailored them to meet the needs of CPSP providers and their clients. The model includes:

- an annotated screening checklist to use with patients
- a flow chart for responding to abuse
- preparation for screening and interviewing patients (including physical and psychological indicators of abuse)
- discussions of battering during pregnancy and the dynamics of domestic violence

Target Audience

Prenatal and postpartum care clients

- suggestions for working with diverse populations
- a screening tool for pregnant women
- the Lethality Assessment (developed by Jacqueline Campbell; see p. 19)
- safety planning materials
- a discussion of California's legal requirements for screening and reporting domestic violence and copies of reporting forms
- body maps and photograph consent forms
- procedures for obtaining a restraining order

Battered teens are recognized as a distinct cultural group in the model. The model's section entitled "Working with Diverse Populations" discusses the fact that teenagers may be particularly vulnerable to submissive sex roles in society and therefore more vulnerable to relationship violence. It also recognizes that teens are often reluctant to turn to authority figures for help or may avoid revealing the true cause of their injuries for fear of parental involvement. Most importantly, the model specifically encourages CPSP providers to refer battered pregnant teens to their local Adolescent Family Life Program (AFLP; see p. 46 for a description of this program) for further assistance where necessary.

To train CPSP providers in the use of the model, technical consultants are working with the CPSP Education and Training Committee to develop a train-the-trainers program. CPSP county coordinators will be trained to train local CPSP providers.

Implementation of the model by CPSP providers is optional; it is primarily intended for private providers not already using county- or hospital-developed domestic violence protocols. One added advantage of the development of the model is that, since many CPSP providers see other pregnant and postpartum clients in their private practices, the model can be used for all clients and not only for the state Medi-Cal clients who are participants in CPSP.

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Available Materials

The *Domestic Violence Brief Intervention Model* is available from the program.

Funding

The California Department of Health Services, Maternal and Child Health Branch, funds CPSP and its Violence Prevention Task Force. Consultants from the Contra Costa County Health Services Community Wellness and Prevention Program and the California Center for Childhood Injury Prevention are funded to provide technical assistance to the task force.

Elmhurst Hospital Center's community health nurses routinely screen for domestic violence as part of their home health visits to pregnant and parenting women. Home health visits are an excellent setting for including domestic violence screening, because home health nurses usually see the same clients over time and discuss a range of health issues, building the foundation for a trusting relationship. This program is an example of an urban home visiting initiative that screens every client for domestic violence and that has developed screening tools for its home visitors.

Domestic Violence Screening and Response System

Elmhurst Hospital Center Maternal and Child Home Health Care Program

- ✔ home visiting by community health nurses
- ✔ domestic violence screening tools for home visitors

Description

The Elmhurst Hospital Center Maternal and Child Home Health Care Program provides home visiting services to pregnant women and girls. Clients of this program are referred primarily from two municipal hospitals located in the multi-ethnic, urban setting of Queens, New York. These clients are generally at high risk for medical problems in pregnancy or have children with medical problems. They tend to come from low-income backgrounds and represent many racial and cultural groups; a significant number are immigrants. Approximately 25 percent of clients are teenagers.

In response to client disclosures of domestic violence, the agency developed a domestic violence screening tool for community health nurses to use during their home visits. The screening tool includes 12 questions:

1. Does anyone in your family hit you?
2. Does your partner ever threaten you?
3. Does your partner ever hit, punch, kick, or shove you?
4. Does your partner ever hurt your child/children?
5. Does your partner ever stop you from leaving the house, seeing family or friends?
6. Does your partner ever destroy things that mean a lot to you?
7. Does your partner ever watch your every move or accuse you of having affairs?
8. Has your partner ever physically hurt you?
9. Do you feel safe in your home?
10. Does your partner ever force you to have sex?
11. If you were abused, who would you feel safe in telling?
12. Where could you stay if you were abused?

Target Audience

Pregnant and parenting women and adolescents, generally of low income

Prior to implementing the screening tool, the nurses participated in an intensive education and training program conducted by local domestic violence specialists. Ongoing training is provided for staff, and new nurses receive individualized training in assessment and intervention.

Since 1993, all clients admitted to Elmhurst's MCH program have been screened for domestic violence as part of the home care program (the program's caseload averages 200 women). The screening is incorporated into the regular visitation schedule, which varies from one to three visits per week over the course of one or more months. Nurses use discretion about at what point in the process to conduct domestic violence screenings, though clients generally are screened after the first visit, in order to establish a relationship, and before the last visit, in order to allow time for follow-up issues.

Nurses also follow a protocol outlining the steps to take when a woman reports domestic violence. The protocol mandates that all clients who disclose are—at a minimum—given phone numbers of local services and shelters for domestic violence victims. Nurses then encourage clients to discuss plans for safety and will pursue next steps with clients who are ready. In addition, social workers from Elmhurst Hospital Center make follow-up phone calls and arrange for visits with clients who express interest. Although clients are told that speaking with a social worker is voluntary, in the history of the program no client has refused this service. If a client is not immediately interested in making changes in her life, a social worker is available to work with her if she becomes ready at a later date. Similarly, in cases of suspected abuse, nurses will bring up the topic again in later visits. Nurses have found that women who do not disclose initially may do so in later visits, if given the opportunity.

Program staff have also developed specific Nursing Standards of Care and Practice for screening for and responding to domestic violence. Standards of care and practice are used by many health care institutions to ensure that quality care is provided and to standardize care for all clients. Such standards are usually formulated for diagnostic categories such as gestational diabetes, urinary tract infections, and so forth. Elmhurst's domestic-violence-specific Standards of Care specify the services and information provided to all clients, including universal screening, education about the types of abuse and the cycle of violence, safety planning and referrals for women who disclose abuse, and emotional support for women's decisions. The Standards of Practice detail the role of the community health nurse in providing these services.

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Available Materials

Copies of the domestic violence screening tool, protocol, and Nursing Standards of Care and Practice are available.

Funding

Clients are generally referred for home health visits by local hospitals. The visits are usually covered by clients' insurance, primarily Medicaid.

In 1995, the Georgia Division of Public Health's Office of Perinatal Epidemiology and Family Health Branch, with assistance from the Centers for Disease Control and Prevention, conducted the Georgia Women's Health Survey (GWHS) of women of reproductive age. The goal of the survey was to acquire detailed, population-based information on women's reproductive health status and health risk behaviors. The GWHS is included here as an example of a state initiative to gather population-based estimates on abuse during pregnancy.

Georgia Women's Health Survey

Georgia Department of Human Resources, Division of Public Health

- ✔ statewide surveillance project
- ✔ data collection on abuse during pregnancy

Description

In response to Georgia's high infant mortality and teen pregnancy rates, the Georgia Women's Health Survey (GWHS) was initiated to explore women's reproductive health needs. The overall goal of the survey was to obtain baseline data on women ages 15 to 44 in order to evaluate and improve state MCH, family planning, and women's health programs. One specific objective of the research was to determine whether certain factors—such as physical violence, sexual abuse, alcohol use, smoking, stress, depression, beliefs and behaviors regarding contraception, and health knowledge and sex education—affect female reproductive behavior.

The GWHS was conducted during 20-minute telephone interviews. Respondents were selected through random-digit dialing. A sample of 4,005 women was selected, and complete interviews were obtained from 3,130 women between January and July 1995, an individual response rate of 78 percent.

The GWHS questionnaire covered a wide range of women's health issues. Specific areas included were:

- demographics
- health care services and utilization
- pregnancy history, prenatal care, and breastfeeding
- sexual experience and current sexual activity
- fertility and fertility preferences
- current contraceptive use and attitudes
- sex education
- mental health
- substance abuse
- domestic violence and sexual abuse

The survey asked an extensive series of questions on violence, including such issues as witnessing domestic violence as a child, past and present abuse by partners, abuse during previous and current pregnancies, threats with weapons by partners, physical injuries incurred from abuse, medical care after injury from abuse, and reporting of abuse. Three questions on sexual abuse were also included.

Target Audience

Women and adolescent girls ages 15 to 44 in Georgia

Preliminary results of the survey, as of July 1996, revealed high levels of physical and sexual violence against women and girls:

- More than 28 percent of respondents had been physically abused by a partner at some point in their lives.
- More than 13 percent of adolescent girls ages 15 to 19 had been physically abused by a partner, and 8 percent of these had been abused during the previous 12 months.
- Seventeen percent of women had been forced to have sexual intercourse; two-thirds of these were under age 20 when they were sexually abused for the first time, and one-fourth were under age 15.
- While 30 percent of women who reported no abuse had become pregnant within the previous 5 years, 37 percent of women who did report abuse had become pregnant within the previous 5 years (and 58 percent of these said the pregnancy was unintended).
- For 5 percent of abused women, the abuse first occurred during pregnancy.
- More than half of women who were abused *before* pregnancy were also abused *during* pregnancy.
- Three-fourths of women abused during pregnancy were abused by a partner who knew the woman was pregnant at the time.

To assess current levels of domestic violence screening by health care providers, the survey also asked each participant if, during the previous 12 months, a doctor or other medical care provider had talked with her about physical abuse by a partner. Among women who reported abuse, only 27 percent had ever been asked by a provider about being abused. And, of women who had been abused during the previous year, 60 percent reported physical injuries from abuse, and half of these saw a provider for those injuries. However, only 54 percent of those who sought care for abuse-related injuries were asked by a provider if they had been abused.

Results of the survey will be used to improve state programs in women's health, family planning, and maternal and child health. Data from the GWHS will be compared with Healthy People 2000 objectives, such as those aiming to reduce infant mortality, physical abuse of women by male partners, teenage pregnancies and unintended pregnancies, and to increase contraceptive use, breastfeeding, and Pap smear testing. Findings will also be used to develop targeted educational messages for the general public and will be published and disseminated to the public health community, the Georgia State Legislature, and the public.

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Available Materials

The preliminary report of the GWHS, a copy of the survey, and a description of the survey methodology are available.

Funding

Funding for the GWHS was provided by the Family Health Branch of the Georgia Division of Public Health, three divisions of the Centers for Disease Control and Prevention (the Division of Reproductive Health, the Division of Birth Defects and Developmental Disabilities, and the Division of Violence Prevention), and the Turner Foundation.

The Healthy Tomorrows Partnership for Children Program began in 1989 as a collaborative venture between the MCHB and the American Academy of Pediatrics. The goal of this initiative is to stimulate innovative programs that prevent disease and disability and promote health and access to health care services for children nationwide. This Healthy Tomorrows project at the New England Medical Center in Boston, Massachusetts, is working to reduce the risk of injury to children of adolescent parents, beginning during the prenatal period. It is an example of how providing ongoing education and support in creating a safe home environment can serve as an access point for discussions about family violence.

Injury Prevention for Pregnant and Parenting Teens: A Home Visiting Model

New England Medical Center Adolescent Prenatal and Family Clinic
A Healthy Tomorrows Project

- ✔ integrating family violence screening into home-based injury prevention
- ✔ adolescent focus
- ✔ research demonstration project

Description

The Injury Prevention for Pregnant and Parenting Teens demonstration project is part of a comprehensive array of services for pregnant and parenting adolescents who are patients of New England Medical Center's Adolescent Prenatal and Family Clinic. The clinic provides full health care and social services, using a "one-stop-shopping" approach to reaching high-risk adolescents during the vulnerable period of pregnancy and early parenting. Teens are referred to the program by clinic staff at local community health centers and high schools.

The goal of the injury prevention component is to reduce the risk of injury among the children of adolescent parents through a model of home-based injury prevention. A full-time lay outreach worker visits patients at their homes, beginning prenatally and continuing for three years after the birth of the child. The home visitor uses screening instruments and resources developed by the Massachusetts Statewide Childhood Injury Prevention Program (SCIPP) and from The Injury Prevention Program (TIPP) of the American Academy of Pediatrics (AAP). These materials have been modified to address the needs of adolescent parents, using simplified handouts and placing greater emphasis on face-to-face education. The home visitor inspects the home to identify hazards, counsels the adolescent parents about household safety, and distributes and installs safety devices such as smoke detectors, window guards, and child safety seats. The distribution and installation of free safety devices are well received by the adolescents, many of whom are unaware of the need for such devices or how to install them properly and often cannot afford to purchase them. Firearm safety is also explicitly addressed through a routine screening question, asked both by the home visitor and by physicians and/or social workers in the clinic.

Significantly, home visitation fosters a relationship of trust between the outreach worker and the adolescent parent(s). In the process of educating clients in injury prevention and household safety, the home visitor develops an ongoing relationship with the adolescent parents and serves in a supportive role. If violence is disclosed or suspected, the home visitor immediately refers the case to social workers at the clinic and provides immediate support and referral services to the victim as needed. The ongoing relationship also allows for discussions of effective parenting strategies, ways to reduce parental stress, child discipline without violence, and other issues of interpersonal relation-

Target Audience

Pregnant and parenting teens and their children

ships and safety. All clients in the home visiting program are also screened by physicians, social workers, and/or nurse practitioners for domestic violence as part of intake procedures at the clinic and during annual follow-up services.

The home visitor has received extensive training in domestic-violence-related issues through various state and local training programs and through another MCHB-funded HealthyTomorrows project: the Pediatric Family Violence Awareness Project (PFVAP) of the Massachusetts Department of Public Health. The PFVAP trains pediatric and perinatal health care providers about the prevalence and effects of partner violence in order to increase supportive responses to battered women and their children. Trainings include a review of practice guidelines using a statewide protocol, *Identifying and Treating Adult and Adolescent Battered Women and Their Children: A Guide for Health Care Providers* (see p. 53). The trainings provide information on the experiences of battered women, the effects on children of witnessing abuse, typical attitudes and behaviors of batterers, identification and care of battered women in health care settings, risk assessment and safety planning, and community resources for victims and perpetrators.

Another project goal is to replicate the model in the hospital's 10 affiliated community health centers. Working with pediatricians and "Parent to Parent" outreach workers, project staff will provide training and technical assistance to improve the delivery of services to pregnant and parenting adolescents, particularly in the areas of injury prevention and outreach.

Evaluation

Evaluation of the project will consist of a comparison of adolescents receiving home-based injury prevention education with a control group receiving the standard office-based injury prevention education. A process evaluation will document that home visitation occurred as planned and will assess the strengths and weaknesses of the program and of client response to the intervention. An outcome evaluation will compare the two groups for knowledge of hazards, use of safety devices, safety practices, reported injuries, and use of physical discipline. In addition, pregnancy and birth outcomes, infant outcomes, and client compliance with scheduled prenatal and well-child visits will be compared with standard outcomes for other adolescent pregnancy and parenting programs.

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Available Materials

Copies of screening instruments and resource materials are available from the project. *Identifying and Treating Adult and Adolescent Battered Women and Their Children: A Guide for Health Care Providers* is available from the Massachusetts Department of Public Health (see p. 53).

Funding

The project is supported by the Maternal and Child Health Bureau, Health Resources and Services Administration, U.S. Department of Health and Human Services.

Partners for a Safe Future: A Violence Prevention Program for Adolescent Mothers

Harvard Pilgrim Health Plan Foundation

- ✔ mentoring for pregnant teens
- ✔ medical student training
- ✔ adolescent focus
- ✔ managed care involvement

Developed by the Teaching Center of Harvard Pilgrim Health Plan, one of the largest HMOs in New England, this program uses first-year medical students to enhance the care provided to pregnant teenagers and to screen for domestic violence and other health risks. The model takes the unique approach of combining domestic violence training for health care providers with an intervention for at-risk patients. It is also an example of how HMOs and other managed care organizations can become involved in violence intervention and teen parenting services.

Description

In 1990, a pilot program that matched Harvard University medical students with pregnant teenagers at Kenmore Health Center in Boston revealed a higher incidence of violence in the lives of pregnant teen patients than was anticipated. Patients disclosed to medical students information about abuse and violence in their lives that they had not shared with their primary health care providers, and some expressed fears for the future safety of their infants. As a result, the program was redesigned as a violence intervention as well as a pregnancy support program.

The program addresses violence from any source, including parents and siblings, and provides guidance in nonviolent child discipline. The program is also structured to address violence within the context of other social problems and the stresses of pregnancy. Providers consciously avoid designating it as a violence prevention program when working with the pregnant teenagers, so as not to offend patients by presuming they are in violent relationships because of their socioeconomic status or other factors.

The core of the program is the development of a supportive "coaching" relationship between a pregnant teen in her second trimester and a first-year Harvard medical student. Students act as advocates for patients, direct them to appropriate medical and social services, and explain and support the recommendations of health care providers. Participating teenagers are recruited from community health centers that serve as providers for Harvard Pilgrim Health Plan (HPHP).

Patients also attend weekly support groups at Kenmore Health Center, a multispecialty community health center located in a diverse urban neighborhood. These meetings have an educational component as well as a mental health component. HPHP providers teach participants about labor and delivery, postpartum care, nutrition, child development, breastfeeding, and other topics. Mental health clinicians discuss the stresses of pregnancy and motherhood and focus on helping patients interrupt the cycle of violence in their lives. After each support group session, the patients can then meet with their medical student partners to discuss any issues or concerns in confidence.

Target Audience

Urban pregnant adolescents and medical students

Participants are provided with a number of educational materials, including information on violence and safety, healthy peer relationships, healthy pregnancy, and parenting skills. The project also uses materials from HPHP's Violence Prevention Project and the AIDS Prevention Project. In addition, participants receive a *Me and My Baby* diary/workbook in which they can record their thoughts and feelings about the pregnancy, childbirth, and parenting.

Throughout their involvement as patient advocates, the medical students are enrolled in a Harvard Medical School course designed to support their work and provide close supervision. This course work, combined with direct-service experience with pregnant teenagers, enables students to learn about medical care in the context of complex social problems. The program has the added benefit of training health care providers very early in their careers in identifying and responding to domestic violence.

Evaluation

Evaluation of the program has consisted of qualitative telephone surveys of patients after childbirth. During these conversations, patients have expressed many positive experiences with the educational components of the program as well as with their relationships with the medical students.

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Available Materials

Me and My Baby, a diary/workbook, is available, as are other materials from HPHP's Violence Prevention Project.

Funding

Harvard Pilgrim Health Plan Foundation provides funding for the program.

Pregnancy Risk Assessment Monitoring System (PRAMS)

Centers for Disease Control and Prevention

✔ statewide surveillance in multiple states

✔ population-based data on violence during pregnancy

The Pregnancy Risk Assessment Monitoring System (PRAMS) is a grant program administered by the CDC to help states maintain a surveillance system of selected maternal health risk behaviors. This ongoing, population-based surveillance system is designed to supplement vital records data and to generate state-specific data for planning and assessing perinatal health programs. The PRAMS surveillance is particularly significant in that it includes questions on domestic violence during pregnancy, among other questions on various health risk behaviors of pregnant women. PRAMS data were the first to provide population-based prevalence estimates regarding domestic violence and pregnancy.

Description

To help state health departments establish and maintain a surveillance system of selected maternal health risk behaviors that occur before and during pregnancy and during the child's early infancy, the Centers for Disease Control and Prevention (CDC) collaborated with the District of Columbia and five states in 1987 to initiate the Pregnancy Risk Assessment Monitoring System (PRAMS). Seventeen states (Alabama, Alaska, Arkansas, Colorado, Florida, Georgia, Illinois, Indiana, Maine, Michigan, New Mexico, New York, North Carolina, Oklahoma, South Carolina, Washington, and West Virginia) and the District of Columbia currently conduct PRAMS.

PRAMS analyses provide state-specific, population-based estimates on health issues and behaviors affecting pregnant women. These data are particularly useful for planning and assessing how perinatal health programs are addressing the health issues of pregnant women. Findings are distributed to health departments, state legislators, professional societies, social service agencies, and universities to help determine future programmatic, funding, and legislative needs to protect the health of mothers and their children.

The PRAMS questionnaire, which is self-administered by new mothers, collects information on a number of topics, including domestic violence, attitudes and feelings about the pregnancy, prenatal care, psychosocial support and stress, pregnancy-related morbidity, nutrition, alcohol and tobacco use, infant health care, and economic status of the mother. States draw samples of new mothers from birth certificates, and surveys are mailed statewide, with follow-up phone calls to nonrespondents. Average annual sample sizes range from 1,500 to 3,000 women per state. State sampling plans are tailored to meet the individual needs of the state, but data collection procedures and instruments are standardized to permit comparisons of data across states.

The questionnaire contains a *core* section that is identical for all states and a *state-specific* section that enables states to assess particular health risks in their state. The previous PRAMS core questionnaire (Phase II, used from 1990 to 1995) contained one direct question about domestic violence, asking whether the woman's husband or partner had physically hurt her during the 12 months before delivery. The current core questionnaire (Phase III, revised in November 1995) contains three questions directly related to domestic violence during pregnancy and has expanded the choice of potential abuser to husband or partner, family member, friend, or other.

Target Audience

Women of all ages who have recently given birth

The next questions are about physical abuse. Physical abuse means pushing, hitting, slapping, kicking, or any other way of physically hurting someone.

31. During the 12 months before you got pregnant with your new baby, did any of these people physically abuse you? Check all that apply.
    - ❒ My husband or partner
    - ❒ A family or household member other than my husband or partner
    - ❒ A friend
    - ❒ Someone else ⟶ please tell us:_____
    - ❒ No one physically abused me during the 12 months before I got pregnant

32. During your most recent pregnancy, did any of these people physically abuse you? Check all that apply.
    - ❒ My husband or partner
    - ❒ A family or household member other than my husband or partner
    - ❒ A friend
    - ❒ Someone else ⟶ please tell us:_____
    - ❒ No one physically abused me during my pregnancy

    ⟶Go to Question 34

33. During your most recent pregnancy, would you say that you were physically abused more often, less often, or about the same compared with the 12 months before you got pregnant? Check only one.
    - ❒ I was physically abused more often during my pregnancy
    - ❒ I was physically abused less often during my pregnancy
    - ❒ I was physically abused about the same during my pregnancy
    - ❒ No one physically abused me during the 12 months before I got pregnant

From Phase III of the PRAMS Core Questionnaire, November 1995.

The core questionnaire also asks whether any of the woman's health care providers "talked with [her] about physical abuse to women by their husbands or partners" during any prenatal care visits. This question is useful in assessing current levels of domestic violence screening of pregnant women by health care providers.

Several states have added other violence-related questions to the state-specific portion of their PRAMS questionnaires. Alaska's PRAMS survey asks, "During your most recent pregnancy or since your new baby was born, has anyone close to you forced you to have sexual activities when you did not want to?" The Michigan survey asks whether, during her most recent pregnancy, the woman felt she needed "help to reduce violence in [her] home" and "help to reduce violence in [her] community" and whether she received services for either of these needs. In addition, seven states inquire specifically about the existence of firearms in the home.

Data from the violence-related questions in Phase III of PRAMS, which were added in November 1995, will be available in the spring of 1997.

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Available Materials

A descriptive brochure, the core questionnaire, and PRAMS journal articles are available from the CDC. Participating state health departments can be contacted directly for articles and newsletters analyzing state PRAMS data. Information about obtaining PRAMS data is available from state PRAMS coordinators; the CDC will provide a list of state coordinators.

Funding

States compete for funds from the CDC to implement PRAMS, conduct analyses, and present and disseminate findings via a cooperative agreement program. Additional matching funds are provided by states.

Peer mentoring during pregnancy augments clinical care and counseling by enabling abused women and girls to develop an ongoing relationship that can provide support and assistance in obtaining needed services and referrals. This project, conducted by the Houston Department of Health and Human Services, is an example of a local program that combines research on domestic violence interventions during pregnancy with the development of a model mentoring program for abused pregnant women and girls.

Preventing Violence During Pregnancy

Houston Department of Health and Human Services

- ✔ research demonstration project
- ✔ city-based intervention
- ✔ mentoring program for abused pregnant women

Description

In 1994, the Houston Department of Health and Human Services was awarded funds for a demonstration project to assess the ability of a mentoring program for abused pregnant women to reduce postpartum abuse. One goal of the project is to test the hypothesis that abused women who receive comprehensive support services during pregnancy, including mentoring by peers trained in domestic violence intervention, will show a greater reduction in postpartum abuse than women who receive domestic violence counseling and referral services but no mentoring.

Patients are selected from maternity clinics at three of seven city health centers. They range in age from 15 to 42, and approximately 25 percent are teens. At each of the three maternity clinics, preadmit nurses are trained to conduct an abuse assessment of all prenatal patients. These trainings consist of a general discussion of domestic violence, the viewing of a video that models a nurse conducting an abuse assessment, and detailed instruction in completing assessment forms. Dr. Judith McFarlane, a noted researcher on the issue of domestic violence during pregnancy, provides these trainings using the March of Dimes module, *Abuse During Pregnancy: A Protocol for Prevention and Intervention* (see p. 26). In addition, the nurses receive ongoing support from on-site family violence counselors on a weekly basis.

Patients who disclose abuse are randomly assigned to one of three levels of intervention: Standard Care, Outreach, or Minimal Intervention. *Standard Care* consists of on-site individual counseling and referral by family violence counselors. *Outreach* consists of the Standard Care plus peer mentoring by community residents who have been trained to provide social support, educational, and referral services for the abused maternity patients. Patients in both the Standard Care and Outreach groups receive unlimited numbers of sessions, depending on individual needs. *Minimal Intervention*, the control for the project, consists of one session with a counselor, who discusses available community resources for abused women, provides suggestions for a safety plan, and gives the patient a card with the telephone number of a crisis hot line.

The development of a model mentoring program is a key component of Houston's program to reduce abuse during pregnancy. The mentors are active community residents who are indigenous to the community, a factor that is particularly important because 97 percent of the health centers' clients are Hispanic. Each mentor works with an average of 15 to 20 patients in the Outreach group at any one time. The mentors work 20 hours per week and receive a salary.

Target Audience

Maternity patients at three city health centers, generally of low income; predominantly Hispanic; 25 percent are teens

Mentors receive intensive education in domestic violence issues. They are trained to provide support to the abused women and to encourage them to use available community resources, such as WIC programs, police department family violence units, shelters, the county district attorney's office of family criminal law, job training resources, local food pantries, and various other government and neighborhood resources. Part of the training includes visits to the different community resources so that the mentors can become familiar with them and learn about the different services available to abused pregnant women. The mentors receive training from a local women's center in counseling and crisis intervention, advocacy, peer education, public speaking, and other topics related to pregnancy, such as labor and delivery, prenatal care, and alcohol and drug use during pregnancy.

At least once a month, the mentors meet separately with each patient in a safe and convenient location; they also maintain weekly telephone contact to provide ongoing support and to identify changing needs. The mentors are trained to facilitate monthly group education sessions for the patients. Six rotating educational programs are provided, including Family Violence; Parenting Without Violence; Safety, Power, and Control; Myths and Dynamics of Family Violence; A Life Free from Violence; and Sexuality.

The project acknowledges the need for added incentives to encourage participation. On home visits and at educational sessions, the mentors provide the women in the Outreach group with gifts such as free diapers, school supplies, child safety seats, baby blankets, toiletries, and T-shirts. These incentives are provided as part of the project grant.

Evaluation

The effectiveness of the three levels of intervention is being evaluated through a series of postpartum follow-up interviews with the abused patients. All patients in the three interventions are interviewed every six months for up to two years after delivery. The interview assesses the frequency and severity of any abuse experienced by the patient during the previous six months; it also assesses her use of community resources and her perception of their effectiveness. Patients are provided with cash incentives for participating in these interviews, beginning at $30 for the first interview and increasing to $100 for the fifth and final interview.

In addition, project staff are evaluating the effectiveness of training health professionals to conduct abuse assessments. A random sample of maternity patient records are reviewed annually at two intervention health centers and at a comparison center where no training for health professionals was provided. The reviewer examines medical charts to determine whether or not (1) a routine abuse assessment was conducted and noted in the record, (2) any abuse was recorded in the chart, and (3) the patient was counseled and referred for services.

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Available Materials

The Abuse Assessment Screen, the Severity of Violence Questionnaire, the Resource Utilization Questionnaire, and a manual used by the mentors are available.

Funding

The project is funded by the National Center for Injury Prevention and Control of the Centers for Disease Control and Prevention.

Prevention of Battering During Teen Pregnancy Project

March of Dimes Birth Defects Foundation, Greater Bay Area Chapter

- ✔ community-based program
- ✔ adolescent focus
- ✔ public awareness and education
- ✔ resource and referral materials
- ✔ training module on violence and teen pregnancy
- ✔ teen shelter

The Prevention of Battering During Teen Pregnancy Project was initiated in 1994 with the goal of breaking the cycle of violence for battered pregnant and parenting teenagers in the San Francisco Bay Area. It aims to educate communities about domestic violence and pregnancy and to improve services for those teenagers who are involved in violent relationships. To accomplish its goals, the project draws on core public health and community organizing strategies. Project activities include media advocacy, community education, and professional training, as well as facilitating institutional change and providing direct services to battered pregnant teens.

Target Audience

Pregnant and parenting teenagers

Description

The Bay Area March of Dimes' Prevention of Battering During Teen Pregnancy Project consists of four primary components: (1) the formation of a multidisciplinary coalition to identify issues particular to abused pregnant teens, (2) the development of educational materials and a training module, (3) the implementation of a public awareness campaign, and (4) the establishment of a shelter for pregnant and parenting teens. Each of these components is designed to foster partnerships between the diverse agencies that must come together to serve battered pregnant and parenting teenagers.

The need for this project arose out of a number of serious gaps in services for battered pregnant and parenting teenagers. Efforts to provide referrals for abused pregnant teens in the Bay Area found:

- Many battered women's shelters would not accept unemancipated teenagers.
- Youth shelters were generally not licensed to accommodate teenagers with children.
- Children's Protective Services is not mandated to investigate referrals of teenagers who are battered by partners and not by family members.

In essence, battered pregnant and parenting teenagers often fall between the cracks of adult and children's services. To address these gaps, the Bay Area March of Dimes has convened a multidisciplinary coalition of professionals from domestic violence services, social services, law enforcement, education, legal services, and public health. The coalition's main tasks are to identify needed policy and institutional changes and develop a referral protocol for battered pregnant and parenting teens.

As part of the referral protocol for battered pregnant teens, the project has constructed an easy-to-follow flow chart outlining a battered teenager's options for reporting abuse, making living arrangements, and obtaining legal

services. This flow chart is intended for use by anyone who works with teens, such as teachers, social workers, and attorneys. (An adapted version of the flow chart can be found on p. 23 of this guide.)

Educational materials, including a fact sheet, a Bay Area resource guide, and an assessment tool, have been developed and distributed to professionals who work with teens. Trainings are being conducted for health and human service providers who need improved skills to identify, assess, and serve teenagers who may be victims of domestic violence. Kaiser Permanente, a local HMO, and Physicians for a Violence-Free Society are collaborating with the project and have helped develop a slide-show training module about domestic violence and teenage pregnancy.

The project's public awareness campaign aims to educate the community about the prevalence and effects of domestic violence during pregnancy and about what services are available to protect abused pregnant teens. Creative public service announcements are broadcast on popular teen radio stations. Posters and brochures are widely distributed to health clinics and schools and posted in public areas such as bus stops. All materials include a toll-free telephone number that teenage victims, perpetrators, and witnesses to violence can call for help and referrals. In addition, dramatic performances written and performed by a local teenage street theater group educate teens about the cycle of violence and offer concrete ways to avoid or leave violent relationships. Bay Area print and electronic media have provided extensive coverage of the project.

Another significant outcome of the coalition's work is the newly established Teen Moms Shelter, a six-bed shelter that accepts and provides services for teen mothers and their children. Several local organizations, including Florence Crittenton Services, Legal Services for Children, and the Teenage Pregnancy and Parenting Project, assisted the March of Dimes in developing the shelter. Services include case management, psychological counseling, health care, legal representation and court advocacy, education, vocational counseling, parenting classes, and child care. Counselors also work with the teens to help them find safe living situations when they leave the shelter.

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Available Materials

The slide-show training module, a fact sheet on domestic violence and teenage pregnancy, a resource guide for the Bay Area that includes the flow chart, posters and brochures (in both English and Spanish), and public service announcements are available.

Funding

Funders include Blue Cross, the Maternal and Child Health Branch of the California State Department of Health Services, the Administration for Children and Families of the U.S. Department of Health and Human Services, and the Junior League of San Francisco. The March of Dimes matches these funds in-kind.

The Adolescent Family Life Program (AFLP) Violence and Substance Abuse Prevention Project is designed to increase the capacity of case managers to help reduce and prevent relationship violence and substance abuse among pregnant and parenting teens. Although many states operate similar case management programs, California's AFLP is one of the first to address relationship violence among its clients in a comprehensive manner.

Violence and Substance Abuse Prevention Project

California's Adolescent Family Life Program

- ✔ pregnant/parenting teen focus
- ✔ case management program
- ✔ teen-specific screening tool and protocol
- ✔ substance abuse link

Description

The Adolescent Family Life Program (AFLP) is a case management program designed to improve the physical, social, and economic well-being of pregnant and parenting teenagers throughout California. The only eligibility criteria for AFLP is that a client be pregnant and/or a parent, of either sex, under the age of 18; teens can then remain in the program until they reach the age of 20. AFLP sites include county health departments, county social service agencies, schools, clinics, and community-based organizations.

The Violence and Substance Abuse Prevention Project was initiated in 1994 to increase AFLP's capacity to prevent and respond to teen relationship violence and substance abuse. The project is based on the rationale that ongoing contact between case managers and clients offers opportunities to assess client risks and to provide appropriate prevention services, interventions, referrals, and follow-up assistance. Eight AFLP sites, representative of California's ethnic and regional diversity, have been selected as pilots: Fresno, Nevada, Riverside, Sacramento, San Diego, Santa Barbara, Santa Clara, and Tulare. The project seeks to enhance these sites' ability to address violence and substance abuse issues on four levels:

1. *Client level:* Develop services within AFLP that increase clients' awareness of violence and substance abuse problems and provide them with skills for avoiding abuse.

2. *Program level:* Train AFLP case managers on the nature of violence and substance abuse among adolescents and how best to address these issues.

3. *Community level:* Strengthen and expand existing AFLP provider networks to enhance communication and cooperation among agencies, and increase services for pregnant and parenting adolescents affected by violence and substance abuse.

4. *System level:* Ensure that the state's comprehensive assessment and referral requirements address teen relationship violence and substance abuse.

Each of the eight project sites has conducted a needs assessment to identify domestic violence and substance abuse gaps in services for pregnant and parenting teens. To address these gaps, various site activities include:

Target Audience

Pregnant and parenting adolescents

- seeking additional domestic violence shelter space for teens
- developing alternatives to traditional domestic violence shelter services that address the needs of adolescents
- increasing the number of therapists willing to provide low- or no-fee counseling to AFLP clients
- expanding violence prevention services for teens, such as mentorship and parenting programs
- developing and expanding services to male partners of pregnant and parenting teens, including collaboration with youth violence prevention programs for young men
- training AFLP staff and community service providers in domestic violence and substance abuse prevention

To support the eight pilot sites and to create materials that can eventually be used systemwide, the project developed the *AFLP Violence and Substance Abuse Prevention Tool,* an extensive packet of culturally appropriate materials for case managers to use with teens. The packet contains a Protocol for Screening, Intervention, and Referral; a Teen Relationship Violence Assessment form; and teen-specific safety planning materials. Each component of the tool is accompanied by extensive implementation guidelines for the case managers, explaining the rationale behind each step and the potential barriers and issues that may arise in the process. Included among the implementation guidelines are recommendations on educating teens, instructions for assessing for abuse, strategies for working with domestic violence service providers to ensure that teen-sensitive services are available in the community, and a discussion of legal requirements and options for teens (e.g., reporting to Child Protective Services and/or local law enforcement agencies, accessing legal services, and documenting abuse in client records). The project has also collaborated with the Bay Area March of Dimes' Prevention of Battering During Teen Pregnancy Project (see p. 44) and has included a copy of its flow chart, "Options for Battered Pregnant and Parenting Teenagers," in the packet (see p. 23).

Evaluation

An evaluation of the project is assessing (1) the increase in services to pregnant and parenting teens in the pilot communities, (2) the expansion of service provider networks to which teens may be referred by case managers, (3) the extent to which case managers develop an increased ability to identify and respond to situations of violence and substance abuse, and (4) the effectiveness of the screening and assessment tools in tracking violence and service referrals.

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Available Materials

The *AFLP Violence and Substance Abuse Prevention Tool* is available from the program.

Funding

The California Department of Health Services, Maternal and Child Health Branch, funds AFLP and the Violence and Substance Abuse Prevention Project. This funding provides for a resource coordinator at each of the eight sites and a nurse consultant at the state level, as well as the Contra Costa County Health Services Community Wellness and Prevention Program and the California Center for Childhood Injury Prevention as technical consultants on domestic violence issues.

In response to a clinical research study conducted among its WIC clients, which revealed that 31 percent of clients had been victims of abuse, the St. Clair County Health Department has made screening for domestic violence an integral part of its regular assessment of all women and teens served in its WIC program. This program is as an example of how clinical research in an MCH setting led a county health department to amend its existing procedures to screen all clients for abuse. It also demonstrates the need for domestic violence intervention in nonmedical MCH services.

Women, Infants, and Children (WIC) Program

St. Clair County Health Department

- ✔ integrating screening into WIC services
- ✔ clinical research leading to policy changes

Description

WIC is a federal nutritional program designed to reduce infant mortality and low birthweight and to improve the health of pregnant and postpartum women and their children. WIC provides federal grants to states for supplemental foods, health care referrals, and nutritional education for low-income pregnant and postpartum women, and for infants and children up to age five who are found to be at nutritional risk. WIC food vouchers and educational services are generally provided by city and county health clinics and community-based health and social service organizations.

The WIC program at the St. Clair County Health Department in Belleville, Illinois, serves an average of 2,800 pregnant and postpartum clients and their children. Approximately 23 percent of clients are teens. The client population is diverse, including residents of both urban and rural areas.

In 1994, a study conducted by a researcher from the University of Missouri School of Nursing revealed that a significant number of women receiving WIC services at the St. Clair County Health Department had been abused at some point in their lives. The study, which took place in a WIC classroom at the health department, sampled a total of 400 women ranging in age from 18 to 46. Almost 30 percent were pregnant at the time of the study. Using the Partner Abuse Scale: Physical (PASPH), a survey instrument used to determine physical abuse and gauge its severity, 31 percent of WIC clients had experienced some physical abuse. The study also found correlations between high PASPH scores and other health problems, substance use during pregnancy, and isolation from family and friends.

Immediate follow-up services were provided for women who wished to discuss their experiences with abuse. For those participants who did not seek help, a highly visible announcement was placed on the WIC classroom's bulletin board, explaining that women who have been abused may be in danger of further abuse and listing the phone number of the local crisis center.

In response to these findings, the St. Clair County Health Department has made screening for domestic violence part of its regular assessment of all WIC clients.

Before implementing the screening policy, the department first identified a need for comprehensive staff education about domestic violence. Because WIC is primarily a nutritional program, many staff members had received little to no training in domestic violence. Other WIC providers were nurses whose training in domestic violence varied. The department first assessed staff mem-

Target Audience

Pregnant and parenting women and teens enrolled in a WIC program

bers' understanding of violence-related issues and focused on helping them become more comfortable with the idea of screening for and responding to abuse. Staff viewed videos about domestic violence and attended trainings led by a local women's crisis center, where they participated in role plays on asking clients about possible abuse and responding to disclosures of abuse. Admissions and intake workers also received basic orientations on abuse and were trained to observe interactions between clients and their partners to identify possible abuse situations.

To help staff members fully buy into the new initiative, the department involved the staff in a literature search for various screening tools. Staff assessed which tools would be most useful in their setting and adapted existing protocols and recording forms to include questions on abuse. As a result of the trainings and protocol changes, staff have expressed greater comfort in screening for domestic violence and have identified abuse problems sooner and referred clients to local crisis centers and other applicable services. A nurse case manager is present every day to assist the WIC staff in providing appropriate services to abused clients and to discuss issues and uncertainties about specific cases.

Special reference to domestic violence is now made on a number of forms to reinforce the screening policy and to ensure that abuse disclosures are carefully recorded. The Maternal Health Record, which records the client's health history, pregnancy history, substance use history, and social/environmental history, includes a place for staff to record "any current or previous history of physical abuse" and "any current or previous history of mental abuse." The Infant/Child Health History includes boxes where staff can list "family/social/home problems" and "nerve/emotional/psychological problems." Staff have also been trained to identify cases of abuse as one of the serious "client risk factors" that must be identified and recorded by staff according to the Personal Health Services Protocol for WIC services. The Intra-agency Report Form and the Agency Referral Form have also been modified to allow for recording of information on abuse.

In addition, because all WIC clients are simultaneously enrolled in the health department's Family Case Management program, protocols and recording forms for that program have also been amended to include screening for domestic violence. Family Case Management is a home-visiting program in which nurse case managers visit pregnant women every three months during pregnancy and every two months postpartum until the infant is 12 months old. The nurse case managers, who participated in the health department's domestic violence trainings, observe family interactions and refer questionable cases to nurses on staff at the health department. Nurses meet monthly to discuss high-risk clients and make appropriate referrals to local crisis centers and other services for abused women and teens.

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Available Materials

Copies of protocols and recording forms for WIC and Family Case Management are available.

Funding

WIC is funded by the U.S. Department of Agriculture (USDA) through the Illinois Department of Public Health. Funding for the Family Case Management program is provided by the Illinois Department of Public Aid and the Illinois Department of Public Health.

Part V

Resources

The following publications and other materials address issues of domestic violence in general, violence during pregnancy, and violence in adolescent relationships. These are in addition to materials described within the Programs section (Part IV) of this guide.

Advocacy for Women and Kids in Emergencies (AWAKE)

Schechter, S and Gary, LT. *Health care services for battered women and their abused children: A manual about AWAKE—Advocacy for Women and Kids in Emergencies.* Boston, MA: 1994. A summary of a model mother-child public health family violence intervention project. Suggestions for starting a similar program are included, as are bibliographies, protocols, and a basic data form. Available for $20 from AWAKE, Children's Hospital, 300 Longwood Avenue, Boston, MA 02115; (617) 735-7979.

Alabama Coalition Against Domestic Violence

Treating victims of domestic violence: A resource guide for the Alabama Department of Public Health. Montgomery, AL: 1996. This resource guide was designed to improve the ability of professionals in the Alabama Department of Public Health to recognize and respond to survivors of domestic violence. It describes national and state statistics, common myths about domestic violence, barriers facing patients and health care professionals, and a general protocol for screening and intervention. The guide also discusses special considerations for maternity care, family planning, WIC clients, STD and HIV testing and treatment, child health care, and home care services. Appendixes include a safety plan, body maps, consent forms for photographs, state laws, reporting requirements, and local and other resources. This publication is a useful model for others wishing to develop resource guides for their states. Available for $7.55 from Resource Specialist, Alabama Coalition Against Domestic Violence, Box 4762, Montgomery, AL 36101; (334) 832-4842.

American College of Emergency Physicians (ACEP)

Annals of Emergency Medicine. 27(6) June 1996. Contains eight articles on domestic violence, including how to increase emergency physician recognition, developing an emergency department protocol, overcoming barriers to physician involvement, and issues for health care providers. Available for $10 from Mosby Publishers, (800) 325-4177.

American College of Nurse-Midwives (ACNM)

Paluzzi, P and Quimby, CH. *Domestic violence education module.* Washington, DC: 1995. A module designed to serve as an educational tool for student nurse-midwives as well as continuing education for certified nurse-midwives. It contains extensive readings and many tools, such as assessment tools, documentation guidelines, intervention techniques, and resource information. Available for $23.50 from ACNM, 818 Connecticut Avenue NW, Suite 900, Washington, DC 20006; (202) 728-9863.

American College of Obstetricians and Gynecologists (ACOG)

Domestic Violence Technical Bulletin #209, August 1995.

Special needs of pregnant teens. Patient education brochure AP103. September 1993.

Adolescent pregnancy fact sheet. 1994.

Domestic violence packet. December 1995. Consists of a chronology of ACOG activities on family violence, the Technical Bulletin, a bibliography, *Abused Woman* brochure, fact sheet, and tent card. Posters also available. Available from Deborah Horan, Manager, Special Issues, Division of Women's Health Issues, ACOG, 409 Twelfth Street SW, Washington, DC 20024-2188; (202) 863-2487.

Domestic violence: The role of the physician in identification, intervention, and prevention. 1995. Item #AA-223. A slide-lecture presentation consisting of 68 slides, learning objectives, an instructor's manual, and state and national resource lists. Available for $125 (members), or $150 (nonmembers) from ACOG. (800) 762-2264.

American College of Physicians (ACP)

Domestic violence packet. Includes journal articles, ACP position paper, and other materials. Available from American College of Physicians, Department of Scientific Policy, Health and Public Policy, Independence Mall West, Sixth Street at Race, Philadelphia, PA 19106-1572; (800) 523-1546, ext. 2838.

American Medical Women's Association (AMWA)

Journal of the AMWA. 51(3); May/July 1996: Domestic violence and women's health. Contains 13 articles on domestic violence, including depression in battered women; legal issues for health care practitioners; emergency departments as violence prevention centers; guidelines for doctors on identifying and helping batterers; alcohol, drugs, and domestic violence; and abuse history among incarcerated women. Available for $7 from Journal Fulfillment, AMWA, 801 North Fairfax Street, Suite 400, Alexandria, VA 22314; (703) 838-0500.

Association of Women's Health, Obstetric, and Neonatal Nurses (AWHONN)

AWHONN's Clinical Issues in Perinatal and Women's Health Nursing. Special issue: Domestic violence. 4(3) 1993. Contains 19 articles on battering of pregnant women and teens; sexual abuse; nursing care of African American, Hispanic, Native American, rural, and migrant battered women; development of hospital-based protocols and programs; educational strategies; ethical issues; public policy issues; and screening. Available from Lippincott/Raven Press, P.O. Box 1600, Hagerstown, MD 21741-9932; (800) 638-3030.

California's Comprehensive Perinatal Services Program (CPSP)

The *Domestic Violence Brief Intervention Model* leads perinatal health care providers through the process of screening and assessing pregnant clients for domestic violence as a routine part of perinatal care. (See p. 30 for a description of the model and how it is being used in California's CPS program for Medi-Cal clients.) Available by contacting Xavier Castorena, Public Health Education Consultant, Maternal and Child Health Branch, California Department of Health Services, 744 P Street, P.O. Box 942732, Sacramento, CA 94234; (916) 657-3053; fax (916) 657-1345.

Dating Violence Intervention Project

Sousa C, Bancroft L, German T. *Preventing teen dating violence: A five-session curriculum for teaching adolescents.* Cambridge, MA: second edition, 1996. This curriculum addresses abuse within relationships as well as family violence and sexual assault. Available for $50. A companion manual designed for peer leaders, *Respect can't be beat: Peer leading training manual,* is also available. Both from the Dating Violence Intervention Project, P.O. Box 530, Harvard Square Station, Cambridge, MA 02238; (617) 354-0761.

Family Violence Prevention Fund (FUND)

Resource packets for health care providers. The Fund's Health Resource Center on Domestic Violence focuses on strengthening the health care response to domestic violence by providing resources, training materials, and technical assistance to health care professionals and others serving victims of domestic violence. The center has compiled eight targeted resource packets containing published articles and annotated bibliographies; these include packets for health care providers (general information), emergency departments, primary care, nursing, OB-GYN, screening, protocol development, and mandatory reporting (California-specific).

Improving the health care response to domestic violence. This manual includes information and resources about the dynamics of domestic violence, identification, screening, assessment, and intervention. It also contains materials for patients and clinicians, model protocols, screening and discharge materials, and other clinical tools. $75.

Available from Family Violence Prevention Fund (FUND), The Health Resource Center on Domestic Violence, 383 Rhode Island Street, Suite 304, San Francisco, CA 94103-5133; (888) RX-ABUSE; //www.fvpf.org/fund/.

Healthy Mothers, Healthy Babies (HMHB)

Adolescent pregnancy prevention: A compendium of programs. Washington, DC: 1995. Describes 82 programs around the country, some of which also incorporate dating violence, child abuse, and other violence prevention components. Available for $5 from HMHB, 409 Twelfth Street SW, Washington, DC 20024-2188; (202) 863-2458.

Jacobs Institute of Women's Health

Women's Health Issues. 5(4); Winter 1995. Contains nine articles on domestic violence, including education for physicians and nurses, mandatory reporting by health care providers, the influence of abuse on pregnancy intention, and the health care provider's role in sexual assault prevention. Available from Jacobs Institute of Women's Health, 409 Twelfth Street SW, Washington, DC 20024-2188; (202) 488-4229.

Los Angeles Commission on Assaults Against Women

In touch with teens: A relationship violence prevention curriculum for youth ages 12-19. Los Angeles, CA: 1993. Teaches adolescents and youth ages 12 to 19 not to resort to violence or coercion as a means of resolving conflicts or dominating others. Includes sections on relationship violence, sexual harassment, sexual assault, power and control, and the impact of the media on gender and violence. Activity handouts in Spanish and a bibliography of resources are included. Available from the Los Angeles Commission on Assaults Against Women, 6043 Hollywood Boulevard, Suite 200, Los Angeles, CA 90028; (213) 462-1281.

March of Dimes Birth Defects Foundation

Fact sheet: Domestic violence & teenage pregnancy. 1995. Available without charge.

Helton, AS. *Protocol of care for the battered woman.* White Plains, NY: 1987. A manual outlining a protocol of care, including an abuse assessment tool in English and in Spanish, information about battering, and examples of how to communicate about battering. $7.50

Crimes against the future. 23-minute videotape that presents information for medical professionals about physical abuse of pregnant women by their husbands or partners. $60 purchase; $30 rental.

Abuse during pregnancy: A protocol for prevention and intervention. White Plains, NY: 1994. The March of Dimes Birth Defects Foundation developed this module to train nurses in screening for and responding to domestic violence among pregnant clients (see p. 26 for a detailed description). $15.

These items are available from the March of Dimes Birth Defects Foundation, March of Dimes Fulfillment Center, P.O. Box 1657, Wilkes-Barre, PA 18703; (800)367-6630.

Helton, AS.. *Relationships without violence: A curriculum for adolescents.* Houston: March of Dimes Foundation. 1987. A curriculum with 10-minute video, available for $65 from Texas Gulf Coast Chapter of the March of Dimes Foundation, 3000 Wesleyan, Suite 100, Houston, TX 77027; (713) 623-2020.

Massachusetts Department of Public Health

Identifying and treating adult and adolescent battered women and their children: A guide for health care providers. Boston, MA: 1992. The Massachusetts Department of Public Health developed this protocol for health care providers and uses the manual to train providers through the Pediatric Family Violence Awareness Project. Contents include: identifying battered women in clinical settings, reviewing the patient's history, screening guidelines, examination and medical records (including a body map), collecting physical evidence, reporting and using the courts, risk assessment and safety planning, and identifying battered women through their children. The manual also addresses working with battered adolescents, persons with disabilities, rural women, and battered lesbians. Massachusetts-specific resource lists and copies of relevant legislation are provided in the appendix. Available from Liz Roberts, Massachusetts Department of Public Health, Bureau of Family and Community Health, Women's Health Unit, 250 Washington Street, 4th Floor, Boston, MA 02108-4619; (617) 624-5070.

Massachusetts Office of the Attorney General

Diagnosis: Domestic violence. Boston, MA: 1995. A 24-minute video and accompanying study guide for health care professionals that uses real-life examples of women in various clinical settings to illustrate the barriers and opportunities that the health care system presents to battered women. The study guide also addresses legal interventions and mandated reporting within the state of Massachusetts. Available for $13.50 from Dr. Amy Seeherman, Office of the Attorney General, One Ashburton Place, Boston, MA 02108; (617) 727-2200.

National Adolescent Health Information Center (NAHIC)

Adolescent pregnancy prevention: Effective strategies. May 1995. Other fact sheets on adolescent health also available from NAHIC, University of California at San Francisco, 1388 Sutter Street, Sixth Floor, San Francisco, CA 94109; (415) 476-5254.

National Association of County & City Health Officials (NACCHO)

Unintended pregnancy: Prevention strategies for local health departments. Washington, DC: 1996. A document published with support from MCHB, in response to *Best Intentions*, an Institute of Medicine report on unintended pregnancy. Presents goals and action steps that local health agencies can take to become more involved in this issue. Available without charge from NACCHO, 440 First Street NW, Suite 500, Washington, DC 20001; (202) 783-5550.

National Coalition Against Domestic Violence (NCADV)

Teen dating violence resource manual. Denver, CO: 1997. This manual is a tool for service providers to address the issue of dating violence in their communities. Teens' own experiences, taken from a national survey, are included, as well as program information, resources, and guidelines. Available from NCADV, P.O. Box 18749, Denver, CO 80218; (303) 389-1852.

National Domestic Violence Hotline (800) 799-SAFE

A 24-hour nationwide hotline, established by the U.S. Department of Health and Human Services, providing confidential counseling and referrals to local agencies that can assist victims of violence.

Neponset Health Center

Community health center domestic violence protocols: A primary care approach. Boston, MA: 1997. Developed for use by community health center providers, this protocol will assist clinicians to assess for and intervene on behalf of those being victimized by interpersonal violence. It contains adaptations of various other protocols, plus original text, with a focus on including all health center providers in the screening and intervention process, from receptionists to outreach workers to physicians and nurses to lab workers. A Massachusetts-specific resource section is included, as are "how-to" sheets for other states that wish to develop state-specific resource lists. Available from Annie Lewis-O'Connor, Neponset Health Center, 398 Neponset Avenue, Dorchester, MA 02090; (617) 282-3200.

North Carolina Department of Environment, Health, and Natural Resources

Responding to domestic violence: A guide for local health departments. Raleigh, NC: 1996. Developed by the Division of Maternal and Child Health, this guide discusses the role of local health departments in responding to domestic violence.

Chapter 2 addresses specific populations including pregnant women, adolescents, rural women, women with disabilities, and others. A list of North Carolina studies that screened pregnant women for abuse is included. The appendix provides resource lists, teaching tools, and information on legal issues. Available from Jan Capps, North Carolina Department of Environment, Health, and Natural Resources, Division of Maternal and Child Health, P.O. Box 27687, Raleigh, NC 27611-7687; (919) 715-6444.

Northumberland Services for Women

Discovering the child within: The abuse of pregnant women and their children. Kem Murchin Productions: 1992. Designed for use within small support groups of survivors of abuse, these materials incorporate group exercises over 16 weeks, practical information for women, what professionals need to know about abuse, and a listing of Canadian resources. Includes sample body injury form. 30-minute video ($60); 90-page workbook ($15). Available from Northumberland Services for Women, Box 935, Cobourg, Ontario, Canada, K9A 4W4; (905) 372-7056.

Oregon Public Health Association Public Health Nursing Section and Washington State Public Health Association Public Health Nursing Section

Public health nursing domestic violence protocol. 1993. This protocol includes guidelines for assessment, intervention, and documentation, and addresses other public health nursing issues, legal issues, and cross-cultural issues. Includes the Danger Assessment, safety planning tools, and other resources. Available from the Seattle-King County Department of Public Health, QPP Program, 110 Prefontaine Place South, Suite 202, Seattle, WA 98104.

Pennsylvania Medical Society

Domestic violence: One woman's road to freedom—The story of Christine Dotterer, M.D. Harrisburg, PA: Educational and Scientific Trust of the Pennsylvania Medical Society, 1996. A 28-minute videotape for health care professionals that presents a personal account of domestic violence and provides information on how to screen for, identify, and respond to victims of domestic violence. Introduction by the First Lady of Pennsylvania and afterward by the state's Secretary of Health. Available for $24.95 from the Educational and Scientific Trust, Pennsylvania Medical Society, 777 East Park Drive, Box 8820, Harrisburg, PA 17105-8820.

Project SAFE (Safety Assessment For Everyone)

Flitcraft, A and Paranteau, K. *A physician's guide on domestic violence.* Brief guidelines of how to identify and clinically intervene in domestic violence. Also includes a legal primer on Connecticut's family violence laws.

Brochure for patients, with Connecticut resources listed in English and in Spanish.

Training, consultation, and technical assistance also offered. Available from Domestic Violence Training Project, 614 Orange Street, New Haven, CT 06511; (860) 865-3699.

Saskatchewan Institute on Prevention of Handicaps

Domestic violence during pregnancy packet. 1996. Includes a listing of educational resources, journal articles, bibliography, brochure, and booklet. Available for $5 from SIPH, 1319 Colony Street, Saskatoon, Saskatchewan, Canada S7N 2Z1; (306) 655-2512.

Seal Press

Levy, B (ed). *Dating violence: Young women in danger.* Seattle,WA: Seal Press, 1991. Includes a chapter by Judith McFarlane on violence during teen pregnancy.

Levy,B. *In love and in danger: A teen's guide to breaking free of abusive relationships.* Seattle,WA: Seal Press, 1993.

Levy,B and Giggans,P. *What parents need to know about dating violence:Advice and support for helping your teen.* Seattle,WA: Seal Press, 1995.

All available in paperback from Seal Press,(206) 283-7844.

WomanKind

Health professional quick reference card. Provides concise guidelines and practical techniques to respond to domestic violence for health care providers in a variety of settings. Package of 25 available for $50 from WomanKind, Fairview Health System, 6401 Frances Avenue South, Minneapolis, MN 55435; (612) 924-5775.

Wyeth-Ayerst

Domestic violence: A talk by Sarah Buel. Wilkes-Barre, PA: 1992. A 31-minute video for health care providers, featuring a presentation by a survivor of domestic violence who is also a district attorney. Discusses the cycle of battering, how to recognize the symptoms, and ways to provide responsive care. Introduction by Dr. Richard Jones, past president of ACOG. Available for loan from Wyeth-Ayerst, 350 North Pennsylvania Avenue, P.O. Box 7600, Wilkes-Barre, PA 18773-7600; (717) 822-8899.

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